YOUTH CAMP HEALTH EXAM/RECORD
FOR CAMPERS AND STAFF
Physical Exams Are Valid For 3 Years
From Date of Last Examination

☐ Camper
☐ Staff

Please Return Completed Form to the Camp

Name_____ Date of Birth_____ Phone_____

Guardian_____ Address_____

Emergency Contact_____ Telephone_____

Date of Arrival at Camp: _____ Departure Date:_____

TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER:

Date of Exam ____/____/____

_____ May participate in all camp activities

_____ May participate except for: _____

_____

Medical information pertinent to routine care and emergencies:_____

_____

Is this individual taking prescription or over the counter medication(s)? ☐ YES ☐ NO If yes, indicate names of medication(s):_____

Does the individual have allergies? ☐ YES ☐ NO Explain**:** _____

Is the individual on a special diet? ☐ YES ☐ NO Explain**:** _____

Does the individual have special needs? ☐ YES ☐ NO Explain: _____

This camper/staff is up-to-date on all the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and National Advisory Committee on Immunization Practices:

	Yes	**No**		**Yes**	**No**
Measles			Hepatitis B		
Mumps			Diphtheria		
Rubella			Pertussis		
Chickenpox			Polio		
Tetanus					

Comments: _____

_____

_____

Print name of medical care provider: _____

Medical care provider's address: _____

Medical care provider's: City/Town_____ST_____Zip Code_____

_____
Signature of Physician, PA, APRN or RN

_____
Date Form Signed

_____
Telephone Number

Attention Parent/Guardians:

Campers may not be permitted to participate in camp activities without a medical form signed by both parent/guardian and health care provider. In addition, campers may be refused medical treatment at local medical care facilities if medical form is not complete, insurance information is provided and parent/guardian permission has not been granted. *Please give these details your utmost attentions.*

Medical/Accident Insurance Company: _____

Policy Number: _____

Policy Holder: _____

Social Security Number of Policy Holder: _____
(Parent/Guardian)

Employer's Name: _____

Parent/Guardian Authorization: (required for all persons under age 18) This health history is correct so far as I know, and the person named above has my permission to participate in all camp activities except as noted by me of the examining physician. The camp has my permission to provide emergency medical care in the event the camper is injured or ill.

_____
Signature/Date

_____
Print Name

Parent/Guardian Cell Number: _____

If a Camper is on a Prescription Medication that will need to be taken while they are attending Camp they must have the "Authorization For the Administration of Medications" form signed by the Doctor prescribing the Medication. This form is available on line or by mail or fax from Hoop Mountain.

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATIONS

If a Youth Camp chooses to administer medications, the Connecticut State Law and Regulations require an authorized prescriber (M.D., P.A, APRN) or dentist's written order and parent or guardian's authorization for a nurse or camp personnel with current Medication Administration Training to administer medications. **Medications must be in pharmacy prepared containers and labeled with the name of the child, name of the drug, strength, dosage, frequency, authorized prescriber or dentist's name and date of the original prescription. Over the counter medication must be in the original container and labeled with the child's name.**

AUTHORIZED PRESCRIBER OR DENTIST'S ORDER: **Date ____/____/_____**

Name of Child _____ Date of Birth____/____/____
Street Address_____ City/Town _____State _____

Condition for which drug is being administered during camp hours_____
_____

DRUG: Name of Drug, Dose and Method of Administration _____
_____
_____

Times of Administration: ____, _____, ____ Medication shall be administered from ____/____/____-____/____/____

_____

Relevant side effects to be observed, if any _____
_____

If there are side effects, plan for management _____
_____

Is this a controlled drug?_____

Allergies, reaction to, or negative interaction with food or drugs? If YES, list _____
_____

The authorized prescriber or Dentist Name _____Phone # (_____) _____
(Type or Print)
Street Address_____City/Town_____State _____

Authorized Prescriber or Dentist Signature_____

Authorization by Parent/Guardian for the administration of the above medication:

Date: ____/____/____

I hereby request that the above medication, ordered by the authorized prescriber/dentist for my child _____, be administered by the nurse or by camp personnel with current medication administration training. I understand that I must supply the Youth Camp with the prescribed medication in the original container dispensed and properly labeled by an authorized prescriber, dentist or pharmacist. Over the counter medication shall be in the original container labeled by the parent with the child's name. I understand that this medication will be destroyed if it is not picked up within one (1) week following termination of the order.

Name of Parent or Guardian _____Signature _____
Relationship to child _____ Street Address_____
City/Town _____State _____Zip Code _____Phone (_____) _____