

FORM E - WINDHAM-TOLLAND 4-H CAMP - MEDICATION AUTHORIZATION FORM

Camper's Name: Last _____ First _____ Middle _____

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION BY YOUTH CAMP PERSONNEL

If a Youth Camp chooses to administer medications, the Connecticut State Law and Regulations require a physician's or dentist's written order and parent or guardian's authorization for a nurse, first aide, the director, alternate director or youth camp counselor 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, physician's or dentist's name and date of the original prescription.

OVER-THE-COUNTER MEDICATIONS NOT LISTED ON FORM G ALSO REQUIRE A PHYSICIAN'S WRITTEN ORDER AND MUST BE IN THEIR ORIGINAL CONTAINERS.

MEDICATIONS CURRENTLY BEING TAKEN: (Meds brought to camp must be in their original labeled pharmacy container, THIS INCLUDES INHALERS.)

Med #1 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med #2 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med #3 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med #4 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

ATTACH ADDITIONAL PAGES FOR MORE MEDICATIONS.

Identify any medications taken during the school year that participant does/may not take during the summer:

AUTHORIZATION FOR LICENSED MEDICAL PERSONNEL (PHYSICIAN OR DENTIST)

The person named herein may be administered the medications indicated above. In the event the camp nurse is unavailable, camper/staff member (check one) _____ may _____ may not self-administer this medication under the supervision of camp first aide personnel.

Signature _____ Title _____

Physician or Dentist Signature

Printed _____ License # _____

Address _____ City/State/Zip _____

Telephone # _____ Date _____

AUTHORIZATION FOR PARENT/GUARDIAN

I hereby authorize the camp nurse to administer the medications indicated above as ordered by my physician and the camp physician. In the event the camp nurse is unavailable, camper/staff member (check one) _____ may ___ may not self-administer this medication under the supervision of camp first aid personnel.

Signature _____ Relationship to Child _____

Printed Name _____ Date _____

Parent/Guardian Signature

**WINDHAM-TOLLAND 4-H CAMP - MEDICAL EVALUATION
MUST BE GOOD WITHIN 2 YEAR OF CAMPERS LAST DAY AT CAMP**

SCHOOL PHYSICAL AND SPORTS PHYSICALS ALSO ACCEPTED

MEDICAL PRACTITIONER MUST COMPLETE AND SIGN

Name _____ Date of Birth _____
 Guardian _____ Address _____
 Home Phone () _____ Work Phone () _____ Cell Phone () _____
 Emergency Contact #1 _____ Home Phone () _____ Cell Phone () _____
 Emergency Contact #2 _____ Home Phone () _____ Cell Phone () _____
 Date of Arrival at Camp: _____ Departure Date: _____

Date of Exam _____

_____ **May participate in all camp activities.**

_____ **May participate except for:** _____

Medical information pertinent to routine care and emergencies: _____

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 Immunizations Practices:

(If you require a religious exemption for immunizations please contact our office at 860-974-1122)

| | Yes | No | | Yes | No |
|------------|-----|----|-------------|-----|---------|
| Measles | | | Hepatitis B | | |
| Mumps | | | Diphtheria | | |
| Rubella | | | Pertussis | | |
| Chickenpox | | | Polio | | |
| Tetanus | | | TB Test | | Result: |

Comments: _____

Health History: (Check any that apply)

_____ Epilepsy or seizures _____ Frequent ear infections _____ Menstrual problems _____ Asthma
 _____ Frequent sore throats _____ Headaches _____ Bed wetting _____ Heart Disease
 _____ Back pain or strain _____ Alcohol/drug addiction _____ Diabetes _____ Eye Glasses
 _____ Heart Disease OTHER: _____

Pertinent past medical treatment: _____

ALLERGIES

Medication Allergies

Describe reaction and management of reaction

Food Allergies

Other Allergies (including: insect stings, hay fever, asthma, animal dander, etc.)

I have examined the person herein described and have reviewed the health history. It is my opinion that this camper is physically able to engage in camp activities, except as noted above.

_____, M.D. Telephone: () _____ Date: _____

Examining Physician Signature