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 aid, 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

RETURN TO: WINDHAM-TOLLAND 4-H CAMP, 326 TAFT POND ROAD, POMFRET CENTER, CT 06259
Fax (860) 974-3327

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 all 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 **Describe reaction and management of reaction**

Medication Allergies

_____ _____

_____ _____

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

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