FORM E – RETURN WITH FORMS A, B, C, D, F, G

THIS FORM REQUIRES PHYSICIAN'S SIGNATURE

AND PARENT/GUARDIAN'S SIGNATURE

FOR PRESCRIBED MEDICATIONS AND DAILY OVER-THE-COUNTER MEDICATION

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. **Daily Over the counter medication must also be in the original container.**

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.)

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, APRN, 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

❑ Camper
❑ Staff

FORM F – RETURN WIITH FORMS A, B, C, D, E

MEDICAL EVALUATION

MUST BE GOOD WITHIN 2 YEAR OF CAMPERS LAST DAY AT CAMP

SCHOOL PHYSICAL AND SPORTS PHYSICALS ALSO ACCEPTED- Please include immunization record

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: Please attach a copy Camper's immunization record.

(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

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 or APRN Signature

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