

**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			Pneumococcal conjugate		
Tetanus			Polio		

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

## **Authorization for the Administration of Medication**

In Connecticut, licensed Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the CT State Statutes and Regulations. Parents/guardians requesting medication administration to their child while at camp shall provide the program with appropriate written authorization(s) and the medication before any medications are administered. Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and date of the prescription. All unused medication shall be destroyed if not picked up within one week following the camper's departure at the end of camp.

### **Authorized Prescriber's Order (Physician, Dentist, Physician Assistant, Advanced Practice Registered Nurse):**

Name of Child \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Medication Name \_\_\_\_\_ Controlled Drug? ☐ YES ☐ NO

Dosage \_\_\_\_\_ Method \_\_\_\_\_ Time of Administration \_\_\_\_\_

Specific Instructions for Medication Administration \_\_\_\_\_

Medication Administration: Start Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Stop Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Is this medication to be self-administered by the child? ☐ Yes ☐ No

Relevant Side Effects of Medication \_\_\_\_\_

Plan of Management for Side Effects \_\_\_\_\_

Known Food or Drug Allergies? ☐ YES ☐ NO Reactions to? ☐ YES ☐ NO Interactions with? ☐ YES ☐ NO

If "yes" to any of the above, please explain \_\_\_\_\_

Prescriber's Name \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

Prescriber's Address \_\_\_\_\_ Town \_\_\_\_\_

Prescriber's Signature \_\_\_\_\_

### **Parent/Guardian Authorization:**

☐ I request that medication be administered to my child as described and directed above.

☐ I request that medication be self-administered to my child as described and directed above.

Name of Camp \_\_\_\_\_ Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Child's Name \_\_\_\_\_ Address \_\_\_\_\_ Town \_\_\_\_\_

Name of Parent/Guardian Authorizing Administration of Medication as described and directed above:

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Relationship to Child: ☐ Mother ☐ Father ☐ Guardian/Other explain: \_\_\_\_\_

Address \_\_\_\_\_ Town \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

Signature of Parent/Guardian Authorizing Administration of Medication \_\_\_\_\_

**Name of Camp Personnel Receiving Written Authorization and Medication** \_\_\_\_\_

**Title/Position** \_\_\_\_\_ **Signature (in ink)** \_\_\_\_\_

## Medication Administration Record (MAR)

Name of Child \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Pharmacy Name \_\_\_\_\_ Prescription Number \_\_\_\_\_

Medication Order \_\_\_\_\_

Date	Time	Dosage	Remarks	Was This Medication Self Administered?	Signature of Person Observing or Administering Medication
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	

\*Medication authorization form must be used as either a two-sided document or attached first and second page.

☐ Authorization form is complete

☐ Medication is appropriately labeled

☐ Medication is in original container

☐ Date on label is current

Person Accepting Medication (print name) \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_