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.

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) _____

Individual Health Care Plan for a child with Asthma

Child Name: _____ Date of Birth:_____

Parent/Guardian Name: _____

Contact Phone Number: #1 _____ #2 _____

Pediatrician Name: _____ Phone number: _____

Possible Triggers for an asthma attack: _____

☐ **Colds** ☐ **Dust** ☐ **Pollens** ☐ **Grass** ☐ **Exercise** ☐ **Foods:** _____
☐ **Animal:**_____ ☐ **Other Specify:**_____

Is there a risk for severe reaction: ☐ Yes ☐ No

Signs & Symptoms of an allergic reaction may include:
(Please check the most common symptoms your child exhibits)

☐ Wheezing ☐ Restlessness ☐ Fatigue ☐ Persistent Cough ☐ Rapid breathing
☐ Difficulty talking ☐ Other Specify: _____

Child's Medication History:

Has your child ever used medication Asthma? ☐ Yes ☐ No
If yes, what is the name of the medication? _____
How often? (in the past 6 months) _____
How does your child respond when asked to take medication? _____
How would your child respond to a Camp Supervisor administering the medication? _____
If your does not take medication, how is asthma treated? _____
_____
Has your child ever been hospitalized for Asthma? ☐ Yes ☐ No

Treatment Plan:
If an Asthma attack occurs, what steps should the camp staff take?

Please number **IN ORDER** the action steps to be taken.
Note: Every Camp program has a medication policy. If your program cannot administer routine medications per policy then you must select #2, #3 and/or #4 only.

_____ Administer routine medications as prescribed by the physician.
_____ Call parent(s)
_____ Call 91 1
_____ Other (please specify) _____

_____ _____
Parent/Guardian signature Date

ACTION PLAN FOR A CHILD WITH ASTHMA

*This form is to be completed by the child's physician/prescriber of any medication to be administered and **MUST** be accompanied by completed copies of:*

- Authorization for the Administration of Medication
- Individual Health Care Plan

Upon onset of symptoms, the child should be* asked *to sit down in a quiet area and parents/guardians notified.

If the signs & symptoms of an asthma attack occur: *Prescriber should number in order all actions to occur*

_____ Observe the child for increasing symptoms *of* distress

_____ Administer medication: Dose_____of_____ **at onset of symptoms**

_____ Administer medication: Dose_____of_____via (route)_____

if symptoms do not improve within _____minutes of onset

_____ Administer other medication: Name _____ Dose: _____ Frequency:_____

_____ Call 91 1 if symptoms do not resolve and transport to the ER

Note: Do not hesitate to administer prescribed medications or call 911 if symptoms are severe or if parents cannot be reached.

_____ _____ _____ _____

Parent Signature Date Prescriber Signature MD/APRN/PA Date

Individual Health Care Plan for a child with Food, Drug or other allergies (including bee-stings)

Child Name: _____ Date of Birth:_____

Parent/Guardian Name: _____

Contact Phone Number: #1 _____ #2 _____

Pediatrician Name: _____ Phone number: _____

Known Allergies: _____

Is there a risk for severe reaction: ☐ Yes ☐ No

Signs & Symptoms of an allergic reaction may include:
(Please check the most common symptoms your child exhibits when exposed to the allergen)

Mouth:	Itching, swelling of the lips, tongue or mouth
Throat:	Itching of the throat, throat tightness, cough, hoarseness
Skin:	Hives, rash, swelling of the face/extremities
Gastrointestinal:	Nausea, vomiting, diarrhea, cramping
Lung:	Shortness of breath, wheezing, coughing
Heart:	Rapid pulse, fainting, dizziness

Child's Medication History:

Has your child ever used medication for the allergy? ☐ Yes ☐ No

If yes, what is the name of the medication? _____

How often? (in the past 6 months) _____

How does your child respond when asked to take medication? _____

How would your child respond to a Camp Supervisor administering the medication? _____

If your does not take medication, how is the allergy treated? _____

_____

Has your child ever required the use of an EpiPen for the allergy?☐ Yes ☐ No

Treatment Plan:

If exposure to the allergen occurs, what steps should the camp staff take?

Please number **IN ORDER** the action steps to be taken. Note: Every Camp program has a medication policy. If your program can administer **emergency** medications only then selection

_____ Administer emergency medication as prescribed and follow protocol
_____ Administer routine medications as prescribed by the physician.
_____ Call parent(s)
_____ Call 911
_____ Other (please specify) _____

_____ _____

Parent/Guardian signature Date

ACTION PLAN FOR A CHILD WITH FOOD, DRUG OR OTHER ALLERGIES (INCLUDING BEE-STINGS)

*This form is to be completed by the child's physician/prescriber of any medication to be administered and **MUST** be accompanied by completed copies of:*

- Authorization for the Administration of Medication
- Individual Health Care Plan

Upon onset of symptoms, the child should be* asked *to sit down in a quiet area and parents/guardians notified.

If ingestion or *exposure* to the allergen occurs or is suspected: *Prescriber should number in order all actions to occur*

_____ Observe the child for severe symptoms

_____ Administer EpiPen **before** symptoms occur

_____ Administer EpiPen **if** symptoms occur

_____ Administer Benadryl _____mg or Atarax _____mg before symptoms occur

_____ Call 91 1 (and request a paramedic) & transport to ER if symptoms occur

_____ Call 91 1 (and request a paramedic) & transport to the ER if EpiPen is administered

Note: Do not hesitate to administer prescribed medications or call 911 if symptoms are severe or if parents cannot be reached.

_____	_____	_____	_____
Parent Signature	Date	Prescriber Signature MD/APRN/PA	Date