

Mansfield's
Holiday Hill Day Camp

Holiday Recreation Center, Inc., 41 Chaffeeville Road, Mansfield Center, CT 06250-1112
TEL 860-423-1375 FAX 860-456-2444 www.HolidayRecreation.com

HEALTH EXAMINATION 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 _____
Parent/Guardian _____ Address _____
Town _____ State _____ Zip _____
Emergency Contact Telephone _____

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): _____

NOTE: Medications to be administered at camp require a separate form from the camp office or the Forms area of our website.

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			Polio		
Tetanus					

Comments: _____

Print name of medical care provider: _____

Medical care provider's address: _____

Medical care provider's: City/Town _____ ST _____ Zip _____

See other side for Authorization to Administer Over-the-Counter, Camp Physician's Standing Order Medications

Signature of Physician, APRN or PA _____

Date Form Signed _____

Telephone Number _____

**Authorization for the Administration of
Over-The-Counter Medication by Camp Personnel**

State law requires that there be written authorization for all medications, including over-the-counter medications and medicated ointments and creams as approved by the standing orders of the camp physician. Other than any prescription medications specifically ordered and indicated on separate authorization for the administration of medication forms, only the medications listed below may be administered at camp by the camp nurse and are stocked in the camp health center.

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

Camper/Staff Name _____ Date of Birth _____

The camp participant named herein may be administered the following by the camp nurse as approved by the standing orders of the camp physician:

Check "Yes" to approve or "No" to disapprove of the administration of the specific medications listed below.

- Yes No Acetaminophen (dosage as indicated by age/weight) for minor discomfort
 Yes No Anti-itch gel or lotion to insect bite, poison ivy, oak, or sumac
 Yes No Antiseptic ointment to abrasions, scratches, cuts
 Yes No Ibuprofen (dosage as indicated by age/weight) for sore throat discomfort
 Yes No Ibuprofen up to 400mg or Acetaminophen up to 650 mg for menstrual discomfort
 Yes No Lotion or soothing ointment to sunburn
 Yes No NURSE ONLY MAY ADMINISTER Emergency treatment of Allergic Reactions
Epi-pen Jr. for less than 45 pounds, Epi-pen for those over 45 pounds

Note on the Administration of Medications at camp: In most circumstances, medications are administered at camp by one of our licensed Registered Nurses. In certain situations, like after regular camp hours on an overnight and the following Saturday morning, during Mini-Camp and April Vacation Camp, our nurse is not on duty and our health plan operates under the supervision of a Director of First Aid. Only staff trained in the methods of administration of medications and who have received written approval from the trainer indicating successful completion of the medication administration training program shall be allowed to administer medications as prescribed by a camper's physician and as arranged with a camper's family to be administered at camp.

AUTHORIZATION BY PARENT/GUARDIAN

I hereby authorize the camp nurse to administer the medications indicated above as ordered by my physician, or approved by my physician and the camp physician.

Printed Name: _____ Relationship to child _____

Signature: _____ Date _____

SIGNATURE OF LICENSED MEDICAL PERSONNEL (Physician, Connecticut Licensed Advanced Practice R.N., R.N. or a Physician Assistant)

The person named herein may be administered the medications indicated above by the camp nurse as approved by the standing orders of the camp physician.

Signature: _____ Title: _____

Printed _____ License #: _____

Address _____ Phone: _____

City/ST/Zip _____ Date: _____

Name of Camp Personnel Receiving Written Authorization and Medication _____

Title/Position _____ **Signature (in ink)** _____