# SUMMER CAMPS

## HEALTH FORM

_____ _____
CAMPER LAST NAME FIRST NAME MIDDLE INTIIAL DATE OF BIRTH

**CAMP**: ☐ MESSY ☐ MYSTI ☐ MyGIS ☐ Art Camp ☐ Maine Theatre Camp for Kids ☐ Basketball Camp

_____
HOME ADDRESS CITY STATE ZIP CODE HOME PHONE NUMBER

_____ _____ _____ _____
GUARDIAN NAME/RELATIONSHIP CELL PHONE WORK PHONE OTHER PHONE

_____ _____ _____ _____
GUARDIAN NAME/RELATIONSHIP CELL PHONE WORK PHONE OTHER PHONE

IF NOT AVAILABLE IN EMERGENCY, PLEASE NOTIFY:

NAMES: 1._____ PHONE: _____ CELL: _____

2. _____ PHONE: _____ CELL: _____

**ALLERGIES**: Please list any allergies to medications, foods, insect stings or environmental stimuli. PLEASE describe the reaction your child has when exposed to these allergens. Make special note of any anaphylactic reactions – those that require an EPI Pen.

_____

_____

**Medications:**

| | Medicine #1 | Medicine #2 | Medicine #3 |
|---|---|---|---|
| Name: | _____ | _____ | _____ |
| Date Prescribed: | _____ | _____ | _____ |
| Doctor: | _____ | _____ | _____ |
| Doctor's Phone: | _____ | _____ | _____ |
| Dosage: | _____ | _____ | _____ |
| Hours to be Taken: | _____ | _____ | _____ |

Other Instructions: _____
_____
_____

PARENT AUTHORIZATION

This health form is correct as far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted by the examining physician and me.

I hereby give permission to the medical personnel selected by the University of Maine at Machias (UMM**)** to provide routine health care; to administer prescription and over-the-counter medications; to order X-rays, routine tests, treatment, sutures; to release any records necessary for insurance purposes; and to arrange necessary transportation for my child. In the event that I cannot be reached in an EMERGENCY, I hereby give permission to the physician selected by UMM to hospitalize, secure proper treatment for, and to order injection anesthesia, or surgery for my child as named above. This form may be photocopied for trips out of camp.

Signature: _____ Date: _____

Relationship to Camper: _____

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**NAME OF CAMPER**: _____

**CHRONIC HEALTH CONDITIONS** – Please check all that apply. Describe below or attach a separate note to describe any condition that requires special attention while at camp. This information will be shared with appropriate staff members.

☐ This camper has no chronic health concerns.
☐ This camper has the following chronic health concerns:

☐ Headaches ☐ Seizure Condition ☐ Heart Murmur ☐ Diabetes ☐ Bedwetting
☐ Asthma (attach action plan) ☐ Sleepwalking ☐ Frequent Colds/Infections ☐ Lactose Intolerance
☐ Knee, Ankle or Back problems ☐ Eczema/Hives or Other Skin Conditions ☐ Recent Injury
☐ Diarrhea/constipation ☐ Eating disorder ☐ Traveled outside the country in the past 9 months
☐ Any physical limitations _____
☐ Other (please describe) _____

**MENTAL, SOCIAL AND EMOTIONAL HEALTH** - The information you provide below will be shared with great care among medical staff and camp directors. Other staff members will receive this information only when appropriate and necessary. This information will help us prepare for your camper and ensure that he/she has a positive experience.

This camper has been diagnosed with Attention Deficit Disorder (ADD) or (ADHD)? ☐ Yes ☐ No

Has this camper been diagnosed with any other specific mental health concern? ☐ Yes ☐ No
(i.e. depression, OCD, panic/anxiety disorder)
Describe: _____

This camper has seen or is currently seeing a professional to address a diagnosed mental health concern: ☐ Yes ☐ No
If yes, please explain briefly: _____
_____

This camper has a recent emotional health concern (loss, change in family, etc.) ☐ Yes ☐ No
If yes, please explain briefly: _____
_____

**PRIMARY HEALTH CARE PROVIDERS** – Please provide the names and phone numbers of your home physicians.

Pediatrician _____ Phone _____

Orthodontist _____ Phone _____

Dentist _____ Phone _____

Mental Health Provider _____ Phone _____

**MEDICAL INSURANCE INFORMATION:**

This camper is covered by family medical/hospital insurance. ☐Yes ☐No

***Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.***

Insurance Company _____ Policy Number _____

Subscriber _____ Insurance Company Phone Number _____

**WHAT HAVE WE FORGOTTEN TO ASK?** Please provide any additional information about your child's health, which may not have been discussed on this form. Attach another sheet if necessary.

_____

_____

_____

Please complete pages 1, 2 and 3 and return to **UMM** by July 1st. ***(Mail to Naida Pennell, UMM, 116 O'Brien Avenue, Machias, ME 04654.)***

Your medical provider should complete pages 4 and 5, and they can be sent to **UMM** separately **as soon as possible**.

# SUMMER CAMPS

## MEDICAL RECOMMENDATION

NAME OF CAMPER _____ DATE OF BIRTH _____

**CAMP**: ☐ MESSY ☐ MYSTI ☐ MyGIS ☐ Art Camp ☐ Maine Theatre Camp for Kids ☐ Basketball Camp

IMMUNIZATION HISTORY – Please provide the month and year for each immunization or attach another sheet.

| Immunization | Dose 1 | Dose 2 | Dose 3 | Dose 4 |
|---|---|---|---|---|
| Diptheria, Tetanus, Pertussis – DPT | | | | |
| Booster: Tetanus, Diptheria, Acellular Pertussis – Tdap **Must be current within 5 years** | | | | |
| Meningococcal Vaccine (when recommended by your doctor) **Usually given at 11-12 years of age** | | | | |
| Measles, Mumps, Rubella – MMR **2 doses required for camp** | | | | |
| Pneumococcal Polysaccharide Vaccine – PPV | | | | |
| Inactivated Poliovirus – IPV/OPV | | | | |
| Hepatitis A – HepA | | | | |
| Hepatitis B – Hep B | | | | |
| Haemophilus influenza, type B - Hib | | | | |
| Varicella – VZ | | | | |

MEDICAL RECOMMENDATION

Please note a recent set of baseline Vital signs and any physical findings.

Based on the information presented to me and upon examination of this child, I recommend him/her for camp participation. To the best of my knowledge, he/she has not been exposed to a communicable disease within the last 30 days of my examination.

_____ _____
Signature Date

_____ _____
Printed Name Phone

_____
Address

***Mail to Naida Pennell, UMM, 116 O'Brien Avenue, Machias, ME 04654***

# SUMMER CAMPS

## PRESCRIPTION MEDICINE DISPENSING AUTHORIZATION

I hereby certify my child is currently taking medication prescribed by a physician while attending camp. I understand the medication may not be kept by my child but will be safely held by medical personnel until needed. **All medication must be in original containers.**

Child's Name: _____
For Overnight Camps, Room #: _____

**MEDICATIONS**: Please list all medications that your child will be taking while at camp. All medication must be in original container(s).

| Medication | Dose | Frequency (circle) | Time(s) to be given |
|---|---|---|---|
| _____ | _____ | Daily As Needed | _____ |
| _____ | _____ | Daily As Needed | _____ |
| _____ | _____ | Daily As Needed | _____ |

Does your child have any allergies to any other medicines that might be administered (Tylenol, aspirin, Benadryl, Anti-Itch Cream, etc): _____
_____
_____

It is okay for the following over-the-counter medications to be administered to my child:

| | | | |
|---|---|---|---|
| _____Bismuth | _____Ibuprofen (Motrin) | _____Diphenhydramine (Benadryl) | _____Cough drops |
| _____Calamine lotion | _____topical cream | _____Ben-Gay | _____Calcium antacid |
| _____Triple antibiotic ointment | _____Burn gel | _____Antihistamine/decongestant | _____Cold pack |
| _____Acetaminophen (Tylenol) | | | |

All medications, prescription or non-prescription, must be accompanied by a doctor's written prescriptive order.

**Doctor's Signature (MUST HAVE):** _____
Doctor's Name (Printed): _____Phone #: _____
Parent or Guardian's Name: _____
Relationship to Child: _____Mother: _____Father: _____Other: _____
Phone where you can be reached during the day: 1._____2._____

**I hereby give my permission for the above medication to be administered to my child by medical personnel in accordance with the instructions given.**

Signature of Guardian: _____ Date: _____

***Mail to Naida Pennell, UMM, 116 O'Brien Avenue, Machias, ME 04654***

# S U M M E R  C A M P S

## Medicine Distribution

Summer Campers at UMM will need to register all medication with the Health Manager to be stored in Health Services, which is located in Dorward Hall, during their stay at the University of Maine at Machias. Campers may keep their inhalers with them. All prescription medications will be given in accordance with the following policies:

1. All medications will be collected during Check-In on the first day of camp.
2. Parents/guardians will need to submit a Prescription Medicine Dispensing Authorization form at Check-In, which is signed by the parent/guardian.
3. Parents/guardians must also have a signature from the prescribing physician.
4. All medication must be in the original prescription bottle from the pharmacy when given to the Health Manager at Check-In. The bottle must clearly have the patient's name on it, the pharmacist that filled the prescription, the personal physician, prescription number, date prescribed, name of medication and the directions for taking the medicine prescribed.
5. Parents/guardians are responsible for making sure their children have enough medication at camp and for picking up any unused medication at the end of a session.
6. Medication will be dispensed in Health Services, which is located on the 1st floor of Dorward Hall during the meal times:
    a. Breakfast: 8:30a.m.-9:00p.m.
    b. Lunch: 12:00p.m.-1:00p.m.
    c. Dinner: 5:30p.m.-6:00p.m.
    d. Prior to bed – 9:30p.m.-10:00p.m.
7. The Health Manager is responsible for dispensing medication and creating a spreadsheet, tracking campers that are required to take medications and to ensure that all campers have taken their medications at the proper time.
8. If a camper does not take his/her medication during a scheduled time, the Health Manager will notify the Camp Staff. Camp Staff will ensure that the camper receives his/her prescribed medication.
9. The Health Manager will document all actions pertaining to medications at camp.
10. Parents/guardians may stop by Health Services to pick up his/her camper's medication on the last day of camp between 9:30-10:00 a.m. Parents/guardians will be asked to show picture IDs to verify that their name is on the Health Forms.

Should you have questions or concerns please call us at 207-255-1289.

March 2010