PART 1 of 2

Camp Spofford STAFF Medical Form

Front and Back MUST be completed and brought to Camp.
Be sure all areas are filled out and signed.

Note: According to New Hampshire Regulation Wnv-Wq907.09, every participant at camp shall furnish a health history and a physician statement of health status written within two years of participation.

Name: _____ DOB: _____ Age: _____ **M** **F**

Address: _____ City: _____ State: _____ Zip:_____

Emergency Contact:

Parent/Guardian: _____

Parent/Guardian Address (if different than above): _____

Phone: (Home) _____ (Cell) _____

Other Emergency Contact:

Name: _____ Phone: _____

Physician's Name: _____ Phone: _____

ATTACH COPY OF INSURANCE CARD

Medical/Hospitalization Insurance: _____ Policy #: _____

Subscriber's Name: _____ DOB: _____

Date Insurance Started: _____ Type of Policy (HMO, PPO, etc):_____

Medication Administration Policy

In compliance with state law, you must sign a directive for medications if the nurse is to administer medication according to physician's standing orders. The following is a list of medications which we stock in our infirmary*. Please cross off any medications you **do not** want administered and then sign the statement at the bottom. You may provide a substitute medication and write the medication in the space below.

All medications must be brought to the camp nurse with the **original pharmacy labels** and I give permission for the nurse to administer the medication.

Cold Symptoms: Dimetapp, Sudafed, Robitussin, Robitussin DM
Upset Stomach: Tums, Pepto-Bismol or Mylanta
Allergic Reaction: Benadryl (Epi-pen used for severe reaction)
Pain Relief: Tylenol, Ibuprofen
Other: Neosporin, hydrocortisone, Chloraseptic spray/lozenges, Kaopectate, Imodium, Tinactin, Tolnaftate
*or generic substitution

Over the counter medications I will be sending with my child:_____

_____

Emergency Medical Treatment Authorization

1. I give permission to Camp Spofford to authorize medical treatments deemed necessary by camp nurse, licensed physician, dentists, or emergency personnel. (Emergency contact person will be notified immediately.)

Medical Insurance: *If you or your child are taken to Cheshire Medical Center, they will bill you directly. When you receive the bill, please submit it to your insurance company and send a copy to Camp Spofford. Camp Spofford will cover any cost your insurance company will not cover provided that you submit all claims within 1 year of injury. If you do not have medical insurance, you must submit the bill directly to Camp Spofford within 1 year of injury to receive coverage.*

I understand and accept Camp Spofford's Emergency Medical Treatment Authorization and Medication Administration Policy.

Staffer Signnature_____ Date: _____

Parent/Guardian signature (if under 18 yrs old) _____ Date: _____

PART 2 of 2

To Be Filled Out by Your Doctor

I have examined _____(patient) on _____ (date) (must be within two years prior to expected camp entrance date). On this basis, patient is:

☐Able to participate in all camp activities without restrictions.

☐Able to participate in camp activities with these restrictions: _____

Additional Comments/Current Health Problems: _____

Doctor's Name: _____ Phone: _____

Doctor's Signature: _____ Date: _____

To Be Filled Out by Camp Nurse

Health History

Diabetes:___ Asthma:___ Seizures/Convulsions:___ Tuberculosis:___ Depression:___

Anxiety/Panic Attacks:___ Other: _____

Allergies

Foods: _____ Drugs: _____

Seasonal: _____ Environmental: _____

Check (if yes, please give details)

Yes ___ No ___ On a special diet?

Yes ___ No ___ Has been exposed to communicable disease within the last 3 weeks?

Yes ___ No ___ Presently taking any medication?

Details if checked Yes to any of the above questions: _____

_____

_____

Immunization History - *list the date last booster received*

DTap/TDap: _____ Tetanus: _____ Polio: _____

MMR: _____ Hepatitis B (if born on/after 1-01-93): _____

Tuberculin test if given _____ Positive/Negative

Camp Entrance Physical Findings **(to be completed by camp nurse)**

Skin – Hair – Feet: _____

Current Health Problems: _____

Medications: _____

Comments: _____

_____

Nurse _____ Date _____

Recheck for subsequent week(s) Nurse _____ Date _____

Nurse _____ Date _____