565 Chase Parkway, Waterbury, CT 06708
(203) 236-9532 Phone
summercamp@chasemail.org Email
www.chasecollegiate.org Web

Medical Form

		□Male □Female
Camper/Staff Name	DOB	

Parent/Guardian:_____ Tel: (___)____-_____

Address:_____

Emergency Contact:_____ Tel: (___)____-_____

Camp Sessions: □Week 1 □Week 2 □Week 3 □Week 4 □Week 5 □Week 6 □Week 7

TO BE COMPLETED BY MEDICAL PRACTITIONER

Date of Exam ____/____/____

□May participate in all camp activities

□May participate except for:_____

Medical information pertinent to routine & emergencies:_____

_____

Is this individual taking prescription or over the counter medications? □Yes □No

If YES, indicate names of medications:_____

Does the individual have allergies? □Yes □No Explain:_____

Is the individual on a special diet? □Yes □No Explain:_____

Does individual have Special Needs? □Yes □No Explain:_____

This camper/staff is up-to-date on all 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		
Mums			Diphtheria		
Rubella			Pertussis		
Chickenpox			Pneumococcal Conjugate		
Tetanus			Polio		

Comments:

Print name of medical provider: _____ Signature:_____

Medical provider's address:_____ Date Signed:_____

City/State/Zip:_____ Tel: (___) _____-_____

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Permission to Treat

Camper Name

Birth Date

Copy Front & Back of Insurance Card Here:

In the event I cannot be reached in an emergency, I hereby give permission to the emergency responders and/or physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp. I understand that part of the camp experience involves activities and interactions that may be new to my child, and that they come with certain risks and uncertainties beyond what my child may be used to dealing with at home. I am aware of these risks, and I am assuming them on behalf of my child. I realize that no environment is risk-free, and so I have instructed my child on the importance of abiding by the camp's rules, and my child and I both agree that he/she is familiar with these rules and will comply.

I hereby give permission to the camp to provide, seek, and consent emergency treatment for my child, as may be necessary, including but not limited to x-rays, routine tests and treatment, and/or hospitalization. I agree to the release of any records necessary for emergency treatment, referral, billing, or insurance purposes. I agree to full financial responsibility for any treatments ordered and administered.

I understand and agree that this authorization may be maintained in both printed and electronic forms.

Parent Signature

Date

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Authorization for the Administration of Medication

In Connecticut licensed Youth Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child 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.**

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

Name of Child/Student _____Date of Birth_____/_____/_____ Today's Date_____/_____/_____

Address of Child/Student _____Town_____

Medication Name/Generic Name of Drug_____ Controlled Drug? □YES □ NO

Condition for which drug is being administered: _____

Specific Instructions for Medication Administration: _____

Dosage_____Method/Route_____

Time of Administration _____ If PRN, frequency_____

Medication shall be administered: Start Date: _____/_____/_____ End Date: _____/_____/_____

Relevant Side Effects of Medication _____ □None Expected

Explain any allergies, reaction to/negative interaction with food or drugs_____

Plan of Management for Side Effects _____

Prescriber's Name/Title _____ Phone Number (____) ____-_____

Prescriber's Address _____ Town _____

Prescriber's Signature _____ Date _____/_____/_____

Parent/Guardian Authorization:

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

□ I hereby request that the above ordered medication be administered by camp personnel and I give permission for the exchange of information between the prescriber and the camp nurse necessary to ensure the safe administration of this medication.

Parent/Guardian Signature_____ Relationship_____ Date _____/_____/_____

Home Phone # (_____) _____-_____ Work Phone # (_____) _____-_____ Cell Phone # (_____) _____-_____

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SELF ADMINISTRATION OF MEDICATION AUTHORIZATION

Self-administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the camp nurse (if applicable) in accordance with board policy. At camp, inhalers for asthma and cartridge injectors for medically-diagnosed allergies, students may self-administer medication with only the written authorization of an authorized prescriber and written authorization from a student's parent or guardian or eligible student.

Prescriber's authorization for self-administration: □YES □NO _____
Signature Date

Parent/Guardian authorization for self-administration: □YES □NO _____
Signature Date

Camp nurse, if applicable, approval for self-administration: □YES □NO _____
Signature Date

Comments:

****

Today's Date _____Printed Name of Individual Receiving Written Authorization and Medication _____

Title/Position _____ Signature (in ink or electronic) _____

Note: This form is in compliance with Section 10-212a, Section 19a-79-9a, 19a-87b-17 and 19-13-B27a(v.)