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 HEALTH CARE PROVIDER

Date of Exam ____/____/____

May participate in all camp activities ☐ YES ☐ NO

May participate except for: _____

Does the individual have any known medical or emotional illness or disorder that poses a risk to other children or which affects the individual's functional ability to participate safely in a youth camp? ☐ YES ☐ NO

If yes, please explain _____

_____

Are there any prescription or over the counter medication(s) this individual needs to take while at camp? ☐ YES ☐ NO

If yes, indicate names of medication(s):_____

NOTE: A written authorization and parent permission for the administration of medication at camp are required.

Does the individual have any disabilities or special health care needs such as allergies, special dietary needs? ☐ YES ☐ NO

If yes, please explain _____

_____

NOTE: If the camper has a special health care need or disability that requires special care be taken or provided during the time the individual is at camp, an individual plan of care shall be developed with the parent and health care provider and updated as necessary. The plan shall include appropriate care of the camper in the event of a medical or other emergency and signed by the parent and staff responsible for the care of the camper.

If camper/staff is school aged or younger, have they been immunized in accordance with the schedule adopted by the Commissioner of Public Health pursuant to section 19a-7f of the Connecticut General Statutes? ☐ YES ☐ NO

Additional Comments:

_____

_____

Printed Name of Health Care Provider: _____

Address: _____ Phone: _____

Signature of Physician, PA, APRN or RN _____ Date Form Signed: _____

MEDICAL CARE FORM
& Over the Counter Medication Opt Out

Student Name _____ Date of Birth _____

PERMISSION FOR MEDICAL CARE

I hereby grant permission to the Director of LJC, or his designee, to secure appropriate routine or emergency medical treatment for my child while attending LJC. I give the LJC medical staff permission to administer any over the counter medication approved by the covering physician as stated in our policy and procedure for standing orders.

Parent/Guardian Signature: _____ Date: _____

OVER THE COUNTER MEDICATION AND OPT OUT

It is assumed that the Litchfield Jazz Camp can administer all of the following over the counter medications as outlined in our standing orders and approved by our camp doctor. **To OPT OUT** of the administration of any of these medications please initial next to the medicine below. **If all of these medications are <u>approved</u> please sign the bottom.**

Medication Name	OPT OUT (Initial in box)	Medication Name	OPT OUT (Initial in box)
Allegra		Melatonin	
Aloe Gel		Miconazole (anti fungal spray)	
Auralgan (Ear drops)		Midol	
Bacitracin (Ointment)		Milk of Magnesia	
Benadryl		Neosynephrine	
Caladryl lotion		Pepto Bismol	
Cepacol		Prune Juice	
Clariten		Robitussin	
Colace		Solarcaine	
Dayquil		Sudafed PE	
Hydrocortisone (Cream)		TUMS	
Hydrogen Peroxide		Tylenol	
Ibuprofen (Advil)		Vaseline	
Imodium		Vicks Inhalation	
Lactaid		Visine	
Maalox		Zyrtec	

Parent / Guardian Signature _____ Date _____

INSURANCE INFORMATION

Policy Holder's Name: _____

Insurance vendor/provider/company: _____

ID Number: _____ Group Number: _____

PLEASE MAKE SURE YOUR EMERGENCY CONTACTS ARE UP TO DATE