

**YOUTH CAMP HEALTH EXAM/RECORD**

**FOR CAMPER 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 approved please sign the bottom.**

Medication Name	OPT OUT (Initial in box)	Medication Name	OPT OUT (Initial in box)
Allegra		Melatonin	
Aloe Gel		Maalox	
Auralgan (Ear drops)		Miconazole (anti fungal spray)	
Bacitracin (Ointment)		Milk of Magnesia	
Benadryl		New Skin (ointment)	
Caladryl lotion		Oragel (tooth ache gel)	
Cepacol		Prune Juice	
Claritin		Robitussin DM	
Colace		Solarcaine	
Ear Drops (homeopathic)		Sudafed PE	
Emetrol (Nausea relief)		TUMS	
Dayquil		Tylenol	
Hydrocortisone (Cream)		Vaseline	
Hydrogen Peroxide		Vicks Inhalation	
Ibuprofen (Advil)		Visine	
Imodium		Zyrtec	
Lactaid			

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**