

SAMPLE FORM

**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 SPECIFIED MEDICAL PRACTITIONER:

Date of Exam ____ / ____ / ____

_____ May participate in all camp activities
_____ May participate except for: _____

Medical information pertinent to routine care and emergencies: _____

Is this individual taking prescription or over the counter medication(s)? YES NO If yes, indicate names of medication(s): _____

Does the individual have allergies? YES NO Explain: _____

Is the individual on a special diet? YES NO Explain: _____

Does the individual have special needs? YES NO Explain: _____

This camper/staff is up-to-date on all the 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		
Mumps			Diphtheria		
Rubella			Pertussis		
Chickenpox			Pneumococcal conjugate		
Tetanus			Polio		

Comments: _____

Print name of medical care provider: _____

Medical care provider's address: _____

Medical care provider's: City/Town _____ ST _____ Zip Code _____

Signature of Physician, PA, APRN or RN

Date Form Signed

Telephone Number

Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel

In Connecticut schools, licensed Child Care Centers and Group Care Homes, licensed Family Care Homes, and 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, Dentist, Optometrist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist):

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 ___/___/___

School Nurse Signature (if applicable) _____

Parent/Guardian Authorization:

- I request that medication be administered to my child/student as described and directed above
- I hereby request that the above ordered medication be administered by school, child care and youth camp personnel and I give permission for the exchange of information between the prescriber and the school nurse, child care nurse or camp nurse necessary to ensure the safe administration of this medication. I understand that I must supply the school with no more than a three (3) month supply of medication (school only.)
- I have administered at least one dose of the medication with the exception of emergency medications to my child/student without adverse effects. (For child care only)

Parent/Guardian Signature _____ Relationship _____ Date ___/___/___

Parent /Guardian's Address _____ Town _____ State _____

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

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse (if applicable) in accordance with board policy. In a school, 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

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

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.)

Medication Administration Record (MAR)

Name of Child/Student _____ Date of Birth ____/____/____

Pharmacy Name _____ Prescription Number _____

Medication Order _____

Date	Time	Dosage	Remarks	Was This Medication Self Administered?	Signature of Person Observing or Administering Medication
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	

*Medication authorization form must be used as either a two-sided document or attached first and second page.

- | | |
|--|--|
| <input type="checkbox"/> Authorization form is complete | <input type="checkbox"/> Medication is appropriately labeled |
| <input type="checkbox"/> Medication is in original container | <input type="checkbox"/> Date on label is current |

Person Accepting Medication (print name) _____ Date ____/____/____