

SNEMN Summer Camp Health Exam Form

This form needs to be completed by your physician OR a similar form provided from your physician's office that includes: (1) Physical Examination Date (within 3 years of camp date), (2) Up to date Immunization Record and (3) Signature by physician.

First Name _____ Last Name _____ DOB _____

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 this individual have allergies? Yes No Explain: _____

Is this individual on a special diet? Yes No Explain: _____ Does this individual have special needs? Yes No Explain: _____

This camper is up-to-date on all of the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and National Advisory Committee on Immunization Practices: (include dates)

	Yes (Include dates)	No		Yes (Include dates)	No
Measles			Hepatitis B		
Mumps			Diphtheria		
Rubella			Pertussis		
Chickenpox			Pneumococcal		
Tetanus			Polio		

Comments: _____

Print Name of Medical Care Provider _____

Address _____ Phone _____

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

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.)

- Permission form for:
- Epipens
 - Inhalers
 - other emergency needs

Individual Plan of Care for a Child
With Special Health Care Needs or Disabilities

Child's Name: _____ Date of Birth ____/____/____

Special health care need or disability:

Plan for appropriate care of the child in a medical emergency. An individual Plan of Care is necessary when a child has a special health care need or disability and it is necessary that special care be taken or provided while the child is at the youth camp.

Other relevant information: (e.g. precautions to be taken to prevent a medical or other emergency)

Signature(s) of the Parent(s):

Date Signed:

____/____/____
____/____/____

NOTE: Section 428-3(a) requires a child's health record to include information regarding disabilities or special health care needs such as allergies, special dietary needs, dental problems, hearing or visual impairments, chronic illness, developmental variations or history of contagious disease, and an individual plan of care for the child with special health care needs or disabilities. The plan shall be developed with the child's parent(s) and health care provider and updated as necessary. Such plan of care shall include appropriate care of the camper in the event of a medical or other emergency and shall be signed by the parent(s) and staff responsible for the care of the camper.

Please use the reverse side of this form for signature(s) of all staff responsible for the care of this child.