❑ Camper
❑ Counselor
❑ Staff

HARTFORD COUNTY 4-H CAMP, Inc
HEALTH EXAM/RECORD FORM

Physical Exams Are Valid For Three (3) Years From Date of Last Examination

Name: _____ Birthdate: _____ Gender: M F

Address _____ Phone (home)_____

Parent/Guardian Name: _____Phone (mobile) _____

Emergency Contact Name: _____Phone_____

Cabin: _____

Camper Name: _____

TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER

Assessment: **Date of Exam: _____**

Y N Asthma: mild moderate severe exercise induced
Y N Diabetes
Y N Anaphylactic Reaction: food insect other: _____

Y N Seizure Disorder
Y N Allergies (specify): _____
Y N Special diet (specify): _____
Y N Taking prescription and/or OTC medications (specify) :_____

_____

Immunization Record **_____see attached**

	Dose 1	Dose 2	Dose 3	Dose 4
MMR	*	*		
DTaP/DTP	*	*	*	*
OPV/IPV	*	*	*	
Varicella	*	*		
PCV	*			
Hepatitis B	*	*	*	
Tetanus				

The individual has the following problems which may adversely affect his/her experience:

Vision Auditory Speech/language Physical dysfunction Emotional/Social/Behavior

❑ This individual may participate fully in all camp activities
❑ This individual may participate in camp activities with the following restrictions: _____

_____

Medical information pertinent to routine care & emergencies: _____

_____

Comments: _____

_____

Printed name of medical provider
Medical provider's address
Telephone

_____
Signature of MD, PA, APRN, RN designee
Date Signed: _____

Please Note....

The camp has limited facilities in the infirmary; therefore, campers **requiring injections** should contact the Director before enrolling.

Any **ADA accommodations** must be submitted to the Camp Director, in writing, at least 45 days prior to the start of the camping season.

A copy of a medical form from the child's school, sports activities, Scouting or other youth related organization is acceptable, in lieu of enclosed "Youth Camp Health Exam/Record" form, if it includes all of the information and signatures required.

TO PARENTS OF YOUNGSTERS ATTENDING HARTFORD COUNTY 4-H CAMP

During the camp season, the situation sometimes arises where a camper has to be taken to a hospital for emergency treatment, which requires parental consent. Please sign the following form and bring it with you on registration day. Your signature will also signify your approval for the camper to take part in camp hikes, trips, outings, etc.

"In case of emergency, I hereby give permission to the physicians selected by the Camp Director to hospitalize, to secure treatment for, and to order injections, anesthesia, or surgery for my child named below."

"I also give permission to the physicians selected by the Camp Director to advise and treat my child for any illness or medical condition while he/she is at camp."

_____ _____

Camper/Counselor Name Signature of Parent or Guardian

Hospital preference: _____ Town: _____

PARENTS EMAIL REQUEST

*For summer survey and general information please provide your EMAIL ADDRESS:*_____

DEMOGRAPHICS (OPTIONAL)

ETHNICITY	☐ HISPANIC OR LATINO	☐ NOT HISPANIC OR LATINO
RACE	☐ WHITE	☐ BLACK OR AFRICAN AMERICAN
	☐ AMERICAN INDIAN	☐ ASIAN
	☐ ALASKAN NATIVE	☐ NATIVE HAWAIIAN/PACIFIC ISLANDER

This section is to be completed by a parent/guardian

The infirmary at Hartford County 4-H Camp stocks the following over-the-counter medication and prescription medication*. They are administered by a registered nurse or certified medication administrator in accordance with the standing orders by our camp physician. It is not necessary to bring any of these medications to camp unless your child receives them routinely. **Draw a line through and initial any medications you <u>DO NOT</u> want your child to receive.**

Aurodri ear drops
Bacitracin / antibiotic ointment
Benadryl tablets / antihistime
Benadryl elixir
Benadryl cream or spray
Calamine
Caladryl
Clorasetic throat spray
Dimetapp
*Epipen injection for SEVERE, LIFE-THREATING allergic reactions
Eye wash
Hydrocortisine cream
Ibuprofen (Advil or Motrin)
Imodium AD
Lotrimin AF
Maalox / Mylanta
Robitussin
Robitussin DM
Sudafed
Tinactin cream / antifungal cream
Tobrex eye drops
Tums / Calcium Carbonate
Tylenol

Medication Authorization:

I hereby give permission to Hartford County 4-H Camp health care personnel to administer any of the above medication (or their generic equivalent) that I have not drawn a line through and initialed per the Standing Orders of the Camp Physician.

Signature of Parent/Guardian: _____ Date: _____
(or participant if 18 or over)

<u>SUNSCREEN/INSECT REPELLENT PERMISSION</u>

I give my child permission to self-administer the sunscreen and/or insect repellant that he/she brought to camp.

_____ _____

Camper's/Counselor's Name Signature of Parent or Guardian

CODE OF CONDUCT AGREEMENT

I, the camper, have read the basic rules for participation at Hartford County 4-H Camp, Inc., outlined below, and agrees to abide by these rules.
As a camper at Hartford County 4-H Camp, Inc.:

- I will be responsible for appropriate behavior at all times.
- I agree to follow camp policies, rules and regulations.
- I agree to be respectful and refrain from inappropriate language.
- I agree to resolve any conflicts in an appropriate manner, discussing conflicts with my counselor, staff member or Camp Director if necessary.
- I agree to dress appropriately, refraining from clothing which displays inappropriate language or symbols.
- I agree to have fun, make new friends, and experience new and exciting challenges that I will participate in through a "Learning by Doing" experience at 4-H Camp.

Camper signature: _____ Date: _____

Camper name: _____

PHOTO RELEASE EXCLUSION

Sign below **ONLY IF YOU DO NOT GIVE** Hartford County 4-H Camp, Inc. permission to use photographs taken of your child.

I, **_____, do not give permission** to Hartford County 4-H camp to use photographs taken of my child during his/her stay at camp to be used for Hartford County 4-H Camp publications.

Parent/Guardian Signature: _____ Date: _____

EMERGENCY PROCEDURES

To comply with our emergency procedures, Hartford County 4-H Camp, Inc. is requesting that each camper furnish an emergency kit as described below. The kits will only be utilized in the event that we need to evacuate camp. A copy of our emergency procedures is available upon request.

1 pair of shorts	1 set of undergarments
1 tee-shirt	1 pair of socks

Please pack these items in a 1-gallon Ziploc bag clearly marked with your child's name. The emergency kit will be collected by your child's cabin counselor upon arrival and returned prior to the end of the camp session.

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

In Connecticut schools, licensed Child Day Care Centers and Group Day Care Homes, licensed Family Day 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

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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)