

HOUSATONIC COUNCIL- CAMP MEDICAL FORM

Strang Use Only: Week # 1 2 3 4 W



As required by the State of Connecticut, a medical form is needed for every person (youth & adults) participating or staying in camp. This form requires a medical examination every 36 months (3 years) with a yearly update by a parent/guardian (see section B) for people less than 40 years of age. For those 40 and over, a medical exam is required every 12 months (1 year).

THE CAMP WILL NOT ACCEPT ORIGINALS, PLEASE KEEP THE ORIGINALS FOR YOUR RECORDS!!!

SECTION A and SECTION B – YOU FILL OUT: SIGNATURE REQUIRED
(Parent/Guardian if you are under 18)

SECTION C: (& D if applicable) – PHYSICIAN FILLS OUT
(Signature required – See Reverse)

SECTION A: Personal Information & Health History

Name: _____ Sex: M / F Troop/ Pk # _____
Last First M.I.

Address: _____

Town: _____ State: _____ Zip: _____ Age: _____ D.O.B. _____

Telephone Numbers for Parent/Guardian:
(Home) _____ (Work) _____ (Cell) _____

Emergency Contact: _____ Relation: _____
(Other than parent or guardian)

Address: _____

Telephone: (Home) _____ (Work) _____ (Cell) _____

Insurance Carrier: _____ Policy Number: _____

HEALTH HISTORY (X)

Serious Illness _____ Serious Injury _____
Deformity _____ Surgery _____
Cancer _____ *Other _____

GENERAL INFORMATION (X)

Asthma _____ Seizure/Epilepsy _____ Diabetes _____
ADHD _____ Emotional Difficulty _____
Cardiac _____ Blood Pressure _____
Bleeding Disorders _____ Mobility Difficulty _____
Glasses/Contacts _____ Denture/Orthodic _____

*Please explain details of above below or on an attached sheet:

LIST ALL ALLERGIES AND/ OR SPECIAL NEEDS BELOW OR ON AN ATTACHED SHEET:

IMMUNIZATIONS: 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.

Diphtheria/Tetnus/Pertusis (DTaP)	y	n		
Polio (IPV or OPV please circle)	y	n	Varicella	y n
Measles/Mumps/Rubella (MMR)	y	n	Hepatitis B	y n
Meningococcal (MCV4)	y	n	Hepatitis A	y n
Pneumococcal (PCV)	y	n	Last Tetnus date	_____

Please list: 1) ALL medications taken in the past 30 days **prior** to camp arrival 2) Any Physical or Behavior conditions that might affect or limit participation at camp: _____

SECTION B: Medications, Yearly Update & Parent/Guardian Permission

PLEASE CAREFULLY READ THE FOLLOWING: If you disagree with any statements here, please cross out that section and initial it. Explain your wishes in the space provided, attaching additional sheet if necessary.

This medical form is correct so far as I know, and the person names in Section A has permission to participate in all camp activities except as noted on the form by me or on the reverse by the doctor.

In case of accident, injury or illness while at camp, I hereby give my permission to the doctor selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery or injections of medications.

I hereby request that the prescription medication(s) listed on the reverse, ordered by the doctor/dentist for my child, be administered by the camp's Health Officer. I understand that I must supply the camp with the prescribed medication in the original container as dispensed and properly labeled by a doctor or pharmacist and will provide no more than is appropriate for my child's camp stay. I understand that this medication will be destroyed if not picked up within one week after my child leaves camp.

I give my permission for the camp Health Officer to administer over-the-counter medications as directed for conditions as dictated by the Camp Physician (The Housatonic Council's policy on medications at Scout Camp has been formulated to comply with the National Standards of the Boy Scouts of America and the State of Connecticut Health Dept.) Over the counter medications may include: Sunscreen, topically as needed for sun exposure; Bug Repellant, topically as needed q 2-4 hrs; Robitussin (Guifenesin), po, per weight/age dosing for cough without fever as needed q 6 hrs; Benadryl (Diphenhydramine), po, per weight/age dosing for rash/itch, insect bites, as needed, q 4-6 hrs.; Pepto-Bismol liquid or tablets, po, per weight/age dosing for upset stomach without fever, as needed; Clear, Liquid Non-salty Diet for diarrhea (i.e. Flat Non-diet Soda); Milk of Magnesia, po per weight/age dosing for constipation, as needed q 6 hrs (*NOT more than 2 consecutive doses*); Tylenol (Acetaminophen), po, per weight/age dosing for pain, burns, cold symptoms without fever, ear ache, headache, temperature without other symptoms, as needed q 4-6 hrs; Motrin (Ibuprofen), po, per weight/age dosing for pain, menstrual cramps as needed q 6-8 hrs; Saline Gargles, Cepacol Gargles or Throat Lozenge, po, 1 tab for sore throat q 2-4 hrs, for a sore throat without fever, as needed; Bacitracin, topically, for minor abrasions and superficial skin lacerations wound care/infection prevention, as needed; Cortaid 1/2 % or Benadryl Cream, topically for itch/contact dermatitis, as needed; Lotrimin, for athletes foot, per directions on tube, as needed; Calamine Lotion, topically, for poison ivy, as needed, q 1 hr; Solarcaine or Liquid Aloe Vera, topically for mild sunburn, as needed; EPI Pen (*Auto Inject*) & Benadryl (*po, per weight/age dosing*), for **Anaphylactic Reaction** (911 transport to E.R. for medical evaluation and follow-up)

YEAR 1

Signature: _____
Adults over 18 sign here (Parent/Guardian signs for Camper)
Name (print): _____
Relationship: _____ Date Signed: _____
Comment: _____

YEAR 2

Signature: _____
Adults over 18 sign here (Parent/Guardian signs for Camper)
Name (print): _____
Relationship: _____ Date Signed: _____
Comment: _____

YEAR 3

Signature: _____
Adults over 18 sign here (Parent/Guardian signs for Camper)
Name (print): _____
Relationship: _____ Date Signed: _____
Comment: _____

SECTION C: Physical Examination to be completed by a licensed medical provider (a school medical form may be attached in place of Section C).

PROVIDERS PLEASE NOTE: Provider's signature below also authorizes administration of over the counter medications (listed in Section B) by the camp Health Officer.

DIRECTIONS: Write in values where appropriate. Place an (X) for items examined and satisfactory, leave blank if not examined. If there are any abnormalities, please make a note below in the restriction/recommendations/comments section. Use more paper if needed and attach to this form.

Name of Person Examined: _____ Age: _____

Height: _____ Weight: _____ B.P.: ____/____ Pulse: _____ Hearing: *Right* _____ *Left* _____
Vision: *Near* _____ *Far* _____ Glasses: Yes / No Contacts: Yes / No

Growth/Development: _____ Skin/Glands/Hair: _____ Ears: _____ Head/Neck/Thyroid: _____
Ears/Eyes/Nose: _____ Teeth/Tonsils: _____ Cardiovascular: _____ Respiratory: _____
Abdomen: _____ Genitourinary: _____ Genitalia: _____ Musculoskeletal: _____
Neurobehavioral: _____ Hernia: _____ Other (*specify*): _____

Activity Restrictions/ Diet Restrictions / Comments / Medical information pertinent to routine care and emergencies:

The above named person is in satisfactory condition and may engage in all camp activities (**including Hiking, Boating, Swimming, Competitive Sports, Sleeping on Ground**) except where noted above.

Print Name of Medical Provider: _____

Office Address: _____

Phone: _____ State Licensed in: _____ License No: _____

Signature of Medical Provider: _____

Date Signed: _____

PLACE MEDICAL STAMP HERE

SECTION D: Prescription Medications

MUST BE UPDATED EVERY YEAR- FORM GOOD FOR 3 YEARS

To authorize administration of prescription medications to anyone at camp, this section of the medical form must be signed by the physician. Medications WILL NOT be administered unless the Camp Health Officer is in receipt of this form. Please attach a separate sheet if necessary. Thank you.

YEAR 1: Medications currently being taken:

Medication: _____ Dosage: _____ Route: _____ Time: _____

1) _____
Side Effects/Cautions: _____

2) _____
Side Effects/Cautions: _____

3) _____
Side Effects/Cautions: _____

Physician signature: _____ Date: _____

Please Circle if Not Applicable: N/A

YEAR 2: Medications currently being taken:

Medication: _____ Dosage: _____ Route: _____ Time: _____

1) _____
Side Effects/Cautions: _____

2) _____
Side Effects/Cautions: _____

3) _____
Side Effects/Cautions: _____

Physician signature: _____ Date: _____

Please Circle if Not Applicable: N/A

YEAR 3: Medications currently being taken:

Medication: _____ Dosage: _____ Route: _____ Time: _____

1) _____
Side Effects/Cautions: _____

2) _____
Side Effects/Cautions: _____

3) _____
Side Effects/Cautions: _____

Physician signature: _____ Date: _____

Please Circle if Not Applicable: N/A