1. PHYSICIAN FORM

Camp Session
Year

To Parents/Guardians: ***Complete this section*** *and give this form to your child's health-care provider.*

Camper Name:

Camper Home Address:

Gender: Birth Date:

Custodial Parent(s)/Guardian(s) Phone Home: Cell:

Parents/Guardians: STOP here. The rest of this form is to be completed by medical personnel.

Medical Personnel:
Please complete all remaining sections of this form. Attach additional information if needed.
A form provided by healthcare provider is acceptable.

Date of most recent exam:
Month/Day/Year
Physical exam needs to be within last 24 months.

Weight: lbs **Height:** ft in **Blood Pressure:** /

Allergies: □ No Known Allergies

~~□ To foods~~ ***(list):***

□ To medications ***(list):***

□ To the environment - insect stings, hay fever, etc. ***(list):***

□ Other allergies ***(list):***

Describe previous reactions:

Medication: □ No daily medications.

Will take the following prescribed medication(s) while at camp (name, dose, frequency—describe below):

Name Dose Frequency	Name_ Dose_ Frequency
Name Dose Frequency	Name_ Dose_ Frequency
Name Dose Frequency	Name_ Dose_ Frequency

The camper is undergoing treatment at this time for the following conditions: (describe below) □ None

Other treatments/therapies to be continued at camp: (describe below) □ None needed

Do you feel that the camper will require limitations or restrictions to activity while at camp? □No □Yes **If "yes" describe below and add additional information if needed.**

It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above).

Name of licensed provider (please print):

Office Address:

Phone: Date:

Signature of Licensed Provider: Title:

Return to:

UU Rowe Camp and Conference Center
PO Box 273
Rowe, MA 01367
413-339-4954
Fax: 413-376-0417

2. MEDICAL HISTORY FORM

Camp Session
Year

Emergency Information

Camper Name:

Camper Home Address:

Gender: Pronouns: Birth Date:

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name: Relationship to Camper:

Phone: Address: Email:

Second parent/guardian with legal custody to be contacted in case of illness or injury:

Name: Relationship to Camper:

Phone: Address: Email:

Additional contact in case parent/guardian cannot be reached:

Allergies: □ No Known Allergies

This camper is allergic: □ To foods □ To medications □ To the environment *(insect stings, hay fever, etc.)* □ Other allergies

Describe previous reactions below:

Restrictions: □ I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.

□ I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptions. **(Please Attach Restrictions/Adaptions)**

Medical Insurance Information:

This camper is covered by family medical insurance: □ Yes □ No

Include a copy of your insurance card if appropriate: copy both sides of the card so information is legible.

Insurance company: Policy Number:

Subscriber: Insurance Company Phone Number:

Parent/Guardian Authorization for Health Care:

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Custodial Parent/Guardian: Date: Relationship to Camper:

If for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

Camper Name ______ (For Camp Use) Cabin ______ (For Camp Use) Session ______

Camper Name:

Birth Date:

Immunization & Medication Record

Immunization History: provide the month and year for each immunization or attach a copy of immunization forms from health-care providers or state or local government.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Or laboratory evidence of immunity
Measles, mumps, rubella 2 Doses 1 at 12 months or older 1 at 4 weeks after first					
Polio 3 doses IPV or OPV 4th dose if mixed (IPV) (OPV) schedule was used					
Diphtheria, tetanus, pertussis 4 Doses DTaP/DTP/DT					
Children Entering grades 7-10 or between 12-15 years of age TD within last 5 years	Booster				
Children entering grades 11 & 12 or 16-17 years of age TD booster within last 10 years	Booster				
Hepatitis B 3 doses					

Tuberculosis (TB) test Date: □ Negative □ Positive

If your camper has not been fully immunized, please sign the following statement. My child is in good health. I have chosen not to immunize my child for religious/philosophical reasons. I understand and accept the risks to my child from not being fully immunized.

Signature of Custodial Parent/Guardian: Date: Relationship to Camper:

Medication: □ This camper will not take any daily medications while attending camp. □ This camper will take the following daily medication(s) while at camp: "Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. ***The state of MA requires original pharmacy containers with labels which show the camper's name and how the medication should be given. Provide enough of each medication to last the entire time the camper will be at camp.***
Please provide an "Authorization to Administer Medication" form for EACH medication.

Name of medication	Date started	Reason for taking it	When it is given	Amount or dose given	How it is given

The following non-prescription medications are stocked in the camp Health Center and used on an as-needed basis to manage illness and injury. ***Cross out those the camper should not be given.***

Activated Charcoal for poisoning
Aloe for relief from burns
Benadryl for allergic reactions
Calamine lotion, Caladryl, or Rhuli Gel for dermatitis or insect bites
Chlortrimeton (Chlorpheniramine maleate) for allergies & congestion
allergic reactions causing respiratory difficulty
Menthol Cough Drops to relieve cough & throat irritation
Ibuprofen (Advil, Motrin) for headaches, pain, fever
Kaopectate for diarrhea

Maalox for abdominal discomfort
Milk of Magnesia for constipation
Neosporin or *Triple Antibiotic Cream* to prevent infection
Nix Lice Shampoo for removal of lice infestation
Robitussin DM for cough *Epinephrine* for
Sudafed for earaches & congestion *Hall's*
Tinactin for athlete's foot
Tylenol (acetaminophen) for headaches, pain, fever

Camper Name:

Birth Date:

Health History

General Health History: ***Check "Yes" or "No" for each statement.***
Has/does the camper:

1. Ever been hospitalized?.............................. □ Yes □ No
2. Ever had surgery?....................................... □ Yes □ No
3. Have recurrent/chronic illnesses?................ □ Yes □ No
4. Had a recent infectious disease?................. □ Yes □ No
5. Had a recent injury?.................................... □ Yes □ No
6. Had asthma/wheezing/shortness of breath?........ □ Yes □ No
7. Have diabetes?.. □ Yes □ No
8. Had seizures?... □ Yes □ No
9. Had headaches?... □ Yes □ No
10. Wear glasses, contacts, or protective eyewear?.. □ Yes □ No
11. Had fainting or dizziness?.. □ Yes □ No
12. Passed out/had chest pain during exercise?................ □ Yes □ No
13. Had mononucleosis ("mono") during the past 12 months?.. □ Yes □ No
14. If female, have problems with periods/menstruations?........ □ Yes □ No
15. Have problems with falling asleep/sleepwalking?...... □ Yes □ No
16. Ever had back/joint problems?.................................. □ Yes □ No
17. Have a history of bedwetting?................................... □ Yes □ No
18. Have problems with diarrhea/constipation?............... □ Yes □ No
19. Have any skin problems?.. □ Yes □ No
20. Traveled outside the country in the past 9 months?.... □ Yes □ No

Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

Mental, Emotional, and Social Health: ***Check "Yes" or "No" for each statement.***
Has the camper:

1. Been treated for ADD/ADHD?... □ Yes □ No
2. Been treated for an eating disorder?.. □ Yes □ No
3. Been treated for emotional or behavioral difficulties?.. □ Yes □ No
4. Been treated for drug or alcohol abuse/addiction?.. □ Yes □ No
5. Experienced night terrors?... □ Yes □ No
6. Experienced anxiety attacks?... □ Yes □ No
7. Been sexually abused?... □ Yes □ No
8. Had incidents of cutting/harming themselves?.. □ Yes □ No
9. Attempted suicide?... □ Yes □ No
10. Demonstrated acts of aggression?.. □ Yes □ No
11. Been hospitalized for mental/emotional health concerns?... □ Yes □ No
12. Seen a professional to address mental/emotional concerns?…………………………………………………………… □ Yes □ No
13. Had a significant life event that continues to affect the camper's life?………………………………………………… □ Yes □ No
    (history of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact your for additional information.

Field Trip Consent

Parent/Guardian Authorization

The person herein described has permission to participate in all activities of the camp including activities at the camp as well as off-site swimming, field trips and overnight camping trip (when part of the program). Rowe Camp has permission to transport my child by whatever means they deem appropriate.

Signature of parent/guardian or adult camper/staffer____ **Date** _______________________

What have we forgotten to ask? ***Please provide in the space below*** any additional information about the camper's health that you think is important or that may affect the camper's ability to fully participate in the camp program. ***Attach additional information if needed.***

Camper Health Record

Camper Name:

Birth Date:

Health-Care Providers:

Name of Camper's Primary Doctor(s): phone:

Name of Dentist(s): phone:

Name of Orthodontist(s): phone:

Parents/Guardians: STOP here. The rest of this form is completed when the camper arrives at camp. Keep a copy for your records.

Individual Health Record (For Camp Use Only)

Initial Screening **Date/Time:** **Initials:**

□ **Screening** has been conducted according to camp protocal and significant findings noted as follows:

A. Any signs/symptoms of illness or injury upon arrival?........................ □ No □ Yes as noted below
B. History of exposure to communicable disease?.................................. □ No □ Yes as noted below
C. Additions or corrections to information on this health history?........... □ No □ Yes as noted below
D. Medication given to health-care staff?.. □ No □ Yes as noted below
E. Any signs/symptoms of head lice?.. □ No □ Yes as noted below

Provider notes: (date/time/initial all entries)

Exit Note: Check one of the following:

□ Left camp this day with no reported illness or injury symptoms.
□ Left camp this day with the following problem/concern:

This person was told about the problem and instructed about follow-up as noted above:

Date: Time: Initials:

Return to:

UU Rowe Camp and Conference Center
PO Box 273
Rowe, MA 01367
413-339-4954
Fax 413-376-0417

AUTHORIZATION TO ADMINISTER MEDICATION TO A CAMPER
(To be completed by parent/guardian. **One form per medication**)

Name of Camper: ______________________________

Date of Birth: _____________________

Parent/Guardian Name: ____________________________

Home Telephone: ____________________

Emergency Contact Name and Number: ____________________________________

Name of Physician who prescribed medication: ______________________________

Number of Physician: _________________________

Pharmacy Telephone: _____________________

Name of Medication:
Dosage:
Frequency:
Route of Administration (e.g. by mouth, injection…):
Date Ordered: Quantity: Expiration:
Storage Requirements:
Specific Directions (e.g. on empty stomach/with water): ____

Precautions/Possible Side Effects/Adverse Reactions: ____

I hereby authorize Rowe Camp and Conference Center to administer to my child, ____________________,
in accordance with 105 CMR 430.160.

Parent/Guardian Signature: ______________________________ Date: __________

105 CMR 430.160(A)
Medication prescribed for campers shall be kept in original containers bearing the pharmacy label, which shows the date of filling, the pharmacy name and address, the filling pharmacist's initials, the serial number of the prescription, the name of the patient, the name of the prescribing practitioner, the name of the prescribed medication, directions for use and cautionary statements, if any, contained in such prescription or required by law, and if tablets or capsules, the number in the container. All over the counter medications for campers shall be kept in the original containers containing the original label, which shall include the directions for use.

105 CMR 430.160(C)
Medication shall only be administered by the health supervisor or by a licensed health care professional authorized to administer prescription medications. The health care consultant shall acknowledge in writing the list of medications administered at the camp. If the health supervisor is not a licensed health care professional authorized to administer prescription medications, the administration of medications shall be under the professional oversight of the health care consultant. Medication prescribed for campers brought from home shall only be administered if it is from the original container, and there is written permission from the parent/guardian.*

105 CMR 430.160(D)
When no longer needed, medications shall be returned to a parent or guardian whenever possible. If the medication cannot be returned, it shall be destroyed.

*Health Supervisor – A person who is a least 18 years of age, specially trained and certified in at least current American Red Cross First Aid (or its equivalent) and CPR, has been trained in the administration of medications and is under the professional oversight of a licensed health care professional authorized to administer prescription medications