Health Form A – Health History and Treatment Authorization

Camp Wightman ♦ 207 Coal Pit Hill Rd. ♦ Griswold, CT 06351
860-376-2179 ♦ office@campwightman.org

The information on this form is gathered to assist us in identifying appropriate medical care. The Health History and Treatment Authorization Form is to be completed by the parent/guardian of minor campers or by the adult camper/staff member, and must be updated annually. A Report of a Physical Examination (Form B) must be completed by licensed medical personnel at least every three years.

Name	Gender	DOB	Age at camp
Street	City	State	Zip

	Custodial parent / guardian or emergency contact	Second parent / guardian	If parent / guardian is not available in an emergency, contact:
Name			
Home phone			
Work phone			
Cell phone			

Is the camper / staff member covered by medical insurance? ☐ Yes ☐ No

If yes, indicate carrier or plan name ______________________ Group # ______________________

Please attach a copy of the front and back of the health insurance identification card to this form.

Has / does the camper / staff member:	Yes	No		Yes	No
1. Had any recent injury, illness, or infectious disease?	___	___	15. Ever been treated for ADD or AD/HD?	___	___
2. Have a chronic or recurring illness / condition?	___	___	16. Have an orthodontic appliance being brought to camp?	___	___
3. Ever been hospitalized?	___	___	17. Have skin problems (e.g. itching, rash, acne)?	___	___
4. Ever had surgery?	___	___	18. Have diabetes?	___	___
5. Have frequent headaches?	___	___	19. Have asthma / wheezing / shortness of breath?	___	___
6. Ever had a head injury or been knocked unconscious?	___	___	20. Had mononucleosis in the past 12 months?	___	___
7. Wear glasses, contacts, or protective eye wear?	___	___	21. Had issues with diarrhea / constipation?	___	___
8. Ever had frequent ear infections?	___	___	22. Have a history of sleepwalking?	___	___
9. Ever had fainting or dizziness?	___	___	23. If female, have issues with menstruation?	___	___
10. Ever had chest pain during or after exercise?	___	___	24. If female and she has not yet menstruated, has she been told about it?	___	___
11. Ever had seizures?	___	___	25. Have a history of bed-wetting?	___	___
12. Ever had high blood pressure?	___	___	26. Have an eating disorder?	___	___
13. Ever been diagnosed with a heart murmur?	___	___	27. Had emotional or behavioral issues for which professional help was sought?	___	___
14. Ever had back / joint problems?	___	___			

Please explain any "Yes" answers, noting the number of the question. ______________________________

____

____

____

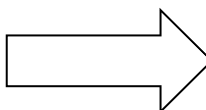
ALLERGIES: List all known allergies, and describe reaction and management of the reaction.

____

____

____

Please continue on back side.



DIETARY or ACTIVITY RESTRICTIONS/LIMITATIONS: ______________________________

____

____

ADDITIONAL INFORMATION about the camper's physical, emotional or mental health of which the camp should be aware: ______________________________

____

____

WHAT ACTIONS should camp take regarding this information: ** Please Attach an **Individual Plan of Care** form______________________________

____

____

STANDING ORDERS: The following non-prescription medications are stocked in the camp's health center, and may be used according to label instructions to treat common ailments. Parents/Guardians should initial next to any medication they **DO NOT** want administered to their camper. In all cases, generic medications may be used in place of name brands.

Medication	I do not want this given to my camper.		Medication	I do not want this given to my camper.
Acetaminophen			Imodium AD	
Bacitracin ointment			Mylanta	
Benadryl			Robitussen DM	
Betadine			Solarcaine Spray	
Hydrocortisone cream			Sudafed	
Ibuprofen			Throat Lozenges	

This section must be signed for attendance at camp.

This health history is correct and accurately reflects the health status of the person to whom it pertains. The person named herein has permission to engage in all camp activities, except as noted.

I give permission to the camp's medical staff to administer the Standing Order Medications shown above.

I give permission to the physicians selected by the camp to order X-rays, routine tests, and treatment related to the health of my child (me) for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give permission to the physician selected by the camp to hospitalize, secure proper treatment for, and order injection, anesthesia, and surgery for my child (me). In addition, the camp has permission to obtain a copy of my child's (my) health record from providers who treat my child (me), and these providers may speak with the camp staff about my child's (my) health status.

I understand the information on this form may be shared on a "need to know" basis with the camp staff.

I give permission to copy this form.

I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

I understand that I will be contacted if my child is exposed to a communicable disease or if medical referral is necessary.

Signature of parent / guardian or adult camper / staff member X ______________________________

Printed name ______________________________ Date ______________

I understand and agree to abide by any restrictions placed on my participation in camp activities for medical reasons.

Signature of camper / staff member ______________________________ Date ______________

INDIVIDUAL PLAN OF CARE

(SPECIAL HEALTH CARE NEEDS or DISABILITIES)

Camper's Name: ____________________________________ Date of Birth: _________________

Health Need or Disability:

____

____

____

Plan for appropriate care for above listed health care need/ disability:

____

____

____

Signature of Parent or Guardian: ______________________________________ Date: ________________

(This section for Camp uses only)

Signature of Health Lodge Representative: ______________________________________

Print Name: _______________________________________ Date:______________________

Other signatures of staff responsible for Camper:

STAFF NAME & TITLE	SIGNATURE	DATE

Health Form B – Report of Physical Examination

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A physical examination must be conducted by licensed medical personnel within three years of the camper's arrival at camp.
A copy of a physical examination for school or sports may be used in lieu of this form.

Name: ____ Gender ____ Date of Birth _____________ Age _____

Date of exam: ____________ BP ____________ Height ____________ Weight ____________

General appraisal: ____
____
____

This camper is under the care of a physician for the following conditions: ______________________________
____
____

KNOWN ALLERGIES: ____
____

Medications: Will this person take any medications (prescription or over-the-counter) while at camp? YES NO
If yes, indicate names of medication(s): ____
____
[Note: Each medication sent to camp must be accompanied by Form C – Authorization for Administration of Medication.]

Does this person take any medications during the school year that he/she will not take while at camp? YES NO
If yes, indicate names of medication(s) and what behaviors/reactions we may see as a result of the "vacation:" ____________________
____
____

RESTRICTIONS / LIMITATIONS to be followed at camp: ____
____
____

ADDITIONAL INFORMATION about the camper's physical health of which the camp should be aware: ____________________
____
____

ADDITIONAL INFORMATION about the camper's emotional / mental health of which the camp should be aware: ______________
____
____

IMMUNIZATION HISTORY: Please complete the immunization history on the back or attach a copy of the immunization history.

I examined this person on the date shown. In my opinion, he/she is able to participate in an active camp program, except as noted.

Health care provider (printed) ____ License # ____________________
Address ____
Signature X ____ Date____________________

IMMUNIZATION HISTORY: Please provide dates of all immunizations or attach a copy of the immunization history.

Vaccine	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTaP					
Tdap					
Haemophilus influenza B					
Hepatitis A					
Hepatitis B					
Meningococcal disease					
MMR					
Pneumonococcal conjugate					
Polio					
Varicella (Chicken pox)					
Other:					
Other:					
Other:					
Other:					

Health Form C – Authorization for the Administration of Medication

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Connecticut camps administering medications to campers are required to comply with all requirements described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their camper while at camp are required to provide written authorization(s) and medication(s) before any medications are administered.

Medications must be in their original container(s) and labeled with camper's name, name of medication, directions for their administration, and date of prescription. Unused medication is destroyed if not picked up within one week of the camper's departure from camp.

A separate form is required for each medication to be administered to your camper.

Authorized Prescriber's Order (Physician, Dentist, Physician Assistant, Advanced Practice Registered Nurse)

Name of Camper ________________________________Date of Birth ______________ Today's Date _____________

Medication Name ____ Controlled Drug? YES NO

Dosage ___________________Method ________________ Time of Administration _________________

Specific Instructions for Medication Administration ____

Start Date _____/_____/_____ Stop Date _____/_____/_____

May this medication to be self-administered by the camper? YES NO

Relevant Side Effects of Medication ____

____

Plan for Management of Side Effects ____

____

Prescriber's name (printed) ____ License # __________________

Address ____ Phone (_____)______________

Signature ____ Date ______________________

Parent/Guardian Authorization: I request that medication be administered to my camper as described and directed above.

Printed Name of parent / guardian ____

Signature ____ Date ______________________

Written Authorization(s) and Medication(s) received by Camp Wightman.

Signature ____ Date ______________________

Medications returned to the camper's family.

Received by ____ Date ______________________

Medication Administration Record

(Camp Health Office use Only)

Camper Name:___________________________________ Medication: __________________________________

DATE	TIME	DOSAGE	REMARKS	Self – Administered?	Signature
				YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	