



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.

Camper's Name _____ Date of Birth _____

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:

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 _____

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

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 _____



Campers Name: _____ Date of Birth: _____

IMMUNIZATION HISTORY: Please provide the 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					
Pneumococcal conjugate					
Polio					
Varicella (Chickenpox)					
Other:					
Other:					
Other:					
Other:					



Health Form C – Authorization for the Administration of **Prescription Medication**

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

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 _____



Health Form D – Authorization for the Administration of Over-the-Counter Medication

Camp Wightman ♦ 207 Coal Pit Hill Rd. ♦ Griswold, CT 06351

860-376-2179 ♦ office@campwightman.org

Connecticut requires individualized standing orders for each camper. The camp's health care staff can only administer according to the doctor's orders for both over-the-counter and prescription medications. For each medication listed below, please check "YES" or "NO" to indicate whether or not you and your physician give the camp health care staff permission to administer the medication to the camper.

Name of Medication	Dosage	Schedule and indications	Yes	No
Benadryl	Per label instructions by age and weight	4-6 hours for mild to moderate Allergic Reaction (insect bites, hives, rashes)		
Ibuprofen	Per label instructions by age and weight	6 hours prn for pain or fever above 100F		
Acetaminophen	Per label instructions by age and weight	4-6 hours prn for pain or fever		
Bacitracin Ointment	Topical	For minor cuts and abrasions		
Hydrocortisone Cream	Topical	For minor itch (insect bites, hives, rashes)		
Imodium Ad	Per label instructions by age and weight	prn for diarrhea		
Mylanta	Per label instructions by age and weight	prn for stomach upset		
Robitussen DM	Per label instructions by age and weight	4 hours prn for cough		
Sudafed	Per label instructions by age and weight	6 hours prn for head cold, sinusitis, or congestion		
Throat Lozenges	1 Lozenge	Not to exceed 8 per day		
Solarcaine Spray	Evenly spray across the affected area	Every 4-6 hours prn for sunburn		

Please list below any additional OTC medications being sent to the camp by the parent/guardian as ordered by the camper's Physician. (Including vitamins.)

Name of Medication	Dosage	Schedule and Indications

By signing below, we, the camper's parent and physician give permission for the camp staff to administer the above medications as directed by the above orders.

Parent/Guardian Signature:			
Physician Signature:			
Name of Physician's Practice:			
Physician's Address:			
City:	State:	Zip:	
Physician's Phone Number:	(____) - ____ - ____ Ext: ____		

NOTICE

According to the State of Connecticut, Camps are no longer allowed to carry stock of over-the-counter medications for campers. Any over-the-counter medications you think your camper will require must be sent from home, including things like ibuprofen, acetaminophen, and Imodium.

Please ensure that form “D” is completed or the camp will not be able to administer any over-the-counter medications to your camper for the duration of their stay.

Like prescription medications, all over-the-counter medications must come in the original bottle with the instructions intact for our health staff to be able to administer.