Health Form
Sigma Camp 2014

Every camper needs a completed health form to participate in Sigma Camp.
Please fill out this form as completely as possible.
The more we know ahead of time, the easier it is to help your child have a successful experience at camp. Thank you!

SECTION I – BASIC CONTACT INFORMATION

Name of Camper ____
LAST FIRST

Gender .... Male .... Female

Birth date ______/ ______/ ______Age ______

Home Address____
STREET CITY STATE ZIP

Home Phone ______________________________

Mother/Guardian #1 Name____

Day Phone ______________________ Night Phone______________________

Father/Guardian #2 Name____

Day Phone ______________________ Night Phone______________________

In the case that we can not reach you...
Additional Emergency Contact #1__________________________Relationship__________

Day Phone ______________________ Night Phone______________________

Additional Emergency Contact #2__________________________Relationship__________

Day Phone ______________________ Night Phone______________________

Family Physician's Name______________________ Phone______________________

Dentist/Orthodontist's Name______________________ Phone______________________

If you are planning to travel during your child's stay at Sigma Camp…
Please inform us in writing of any travel plans. Attach phone numbers, local relative names and numbers, and any other information that would assist us in contacting you in case of emergency. Thank you.

Name of Camper ____

SECTION II – INSURANCE INFORMATION
Is camper covered by family medical/hospital insurance? … Yes … No

If yes, indicate Insurance Carrier ______________________ Group or Policy #______________________

Policy Holder's Name________________________________ Relationship to participant_______________

Policy Holder's SS# or Insurance ID #__________________

SECTION III – MEDICATIONS & RESTRICTIONS
Will camper be taking medications while at camp? Yes No
(Medications include prescription, over-the-counter, vitamins, inhalers, etc.)

If camper will be taking medications while at camp, please list all (prescription and non-prescription). Include the medication name, prescribing physician, physicians' phone number, and the dosage instructions. Use an additional sheet if needed. When you check-in at camp, please provide all medications in their original packaging that identifies the prescribing physician (if prescription drug), the name of the medication, the dosage, and frequency of administration.

Medication______________________ Dosage____________ Take at what times_____________________

Reason for Taking____

Prescribing Physician_____________________________________ Phone_________________________

Medication______________________ Dosage____________ Take at what times_____________________

Reason for Taking____

Prescribing Physician_____________________________________ Phone_________________________

Medication______________________ Dosage____________ Take at what times_____________________

Reason for Taking____

Prescribing Physician_____________________________________ Phone_________________________

Special Instructions or Considerations for Minor Illness

Unless specific instructions are provided, camp health care staff will treat minor illnesses with over the counter medications. If illness persists, parents will be notified

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Physical Activities to be Limited or Restricted while at Camp

____

____

Name of Camper ____

SECTION IV – IMMUNIZATIONS

Please record the month and year of immunizations. If you do not know the dates or whether camper has had certain immunizations, simply leave blank.

DPT (Diphtheria, Pertussis, Tetanus)	________	HIB (Haemophilus Influenza)	________
Tetanus Booster .	________	Tuberculin Test	________
Polio................	________	Varicella (Chickenpox)	________
MMR (Measles, Mumps, Rubella)...	________	Hepatitis B	________

SECTION V – HEALTH HISTORY

Please know that we value your privacy. Health History information is available only to the camp nurse. The nurse may choose to inform the director or your child's counselors only when such knowledge would help your child to have a more successful experience. The more information you provide, the better we can do our job. Thanks!

Has the camper have a history of or is prone to any of the following (Please check all that apply)

… 1. Recent injury, illness or infectious disease
… 2. Chronic or recurring illness
… 3. Asthma
… 4. Homesickness
… 5. History of Bedwetting
… 6. Sleepwalks
… 7. Nightmares / Night Terrors
… 8. Frequent Ear Infections
… 9. Seizure Disorder or Convulsions
… 10. Dizziness during or after exercise
… 11. Chest pain during or after exercise
… 12. Heart Defect/Disease
… 13. Hypertension
… 14. Bleeding/Clotting Disorders
… 15. Diabetes
… 16. Mononucleosis (in last 12 months)
… 17. Joint problems (knees, ankles)
… 18. Frequent ear infections
… 19 Ever had surgery
… 20 Ever been hospitalized
… 21. Frequent Headaches
… 22. Head Injury
… 23. Psychiatric Treatment
… 24. Eating Disorder
… 25. Diarrhea or constipation
… 26. Frequent Stomachaches
… 27. Wears glasses or contacts
… 28. Wears a Medic Alert ID
… 29. Chickenpox
… 30. Measles
… 31. German Measles
… 32. Mumps
…. 33. Tuberculosis
… 34. Hepatitis
… 35. Emotional difficulties for which professional help was sought?

Please list the number and provide explanation for any checked items

____

____

____

For females, has she menstruated? … Yes … No
If not, has she been told about it? … Yes … No

SECTION V I – DIETARY RESTRICTIONS

… Does not eat dairy products
… Does not eat meat
… Does not eat seafood
… Does not eat eggs

Other dietary restrictions *(describe)*: ______________________

Name of Camper ____

SECTION V II – ALLERGIES
List all known allergies and describe reaction and management of reaction:
Medication allergies:
____

____

Food allergies:
____

____

Other allergies--include insect stings, asthma, hay fever, etc.:
____

____

SECTION VIII – PARENT/GUARDIAN AUTHORIZATION

The information provided on this form is accurate to the best of my knowledge.

I have indicated any special health conditions, including required medication and activity limitations which should be known to the camp staff and medical personnel.

I give permission to the camp to arrange for necessary related transportation for my child.

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

I hereby give permission to the camp to provide routine health care and seek emergency medical treatment including ordering x–rays or routine tests. I give permission for the camp health care provider to dispense prescription and non–prescription medications to my child which are approved by a physician, brought with the participant and/or are indicated in standing orders approved by a physician.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above.

I affirm that the camp, its staff and volunteers are held harmless from any liability claims, judgments and costs incurred during my child's stay at the facility or involvement in the camp experience.

I give permission for forms to be copied.

Child name: ____

Signature of parent/guardian: ____

Printed name: ____

Date: ____

PHYSICIANS ORDERS
Health Center Office: (860) 364-5526
223 Low Road Fax: (860) 364-1000
Sharon, CT 06069 www.ctucc.org

A physician must complete this form for ALL (prescription and over the counter) medications that are to be administered at camp!

Name ____ Date _________________
Address ______________________________________ DOB _________________
City _____________________________ State ____________ Zip _________

Medication must be in a prescription container with the name and strength of the Medicine, administration directions and the child's name on the label. Over the Counter medicines should be labeled with name and noted below by the physician.

Authorization for the Administration of Medications by Silver Lake Conference Center The Connecticut State Law requires a written order of a physician licensed to practice medicine in this state and the written authorization of a parent/guardian of such child for a conference center nurse, or in the absence of such nurse, the director to administer medicinal preparations to any conferee.

Name of Drug ____________________ Is this a controlled Substance? Yes ___ No ___
Dosage: _________________________ Method of Administration: _________________
Condition for which drug is being administered:_________________________________

Name of Drug ____________________ Is this a controlled Substance? Yes ___ No ___
Dosage: _________________________ Method of Administration: _________________
Condition for which drug is being administered:_________________________________

Name of Drug ____________________ Is this a controlled Substance? Yes ___ No ___
Dosage: _________________________ Method of Administration: _________________
Condition for which drug is being administered:_________________________________

This child capable of carrying and self-administering (circle): Inhaler Epipen

__________________________________ ____/____/_____
Physician's Signature Date

__________________________________ (_____) ____________
Physician's Name (print) Phone

__________________________________ _____________________________
Street Address City/State/Zip

I hereby permit the administration of the above medication(s) ordered by the physician for my child, __________________. I understand the medication *will be destroyed if not picked up at end of the week, per state law*, General Statues, Sec. 10- 21a CT State Dept of Health Division.

_________________________________ ___/___/____
Signature of Parent or Guardian Date

____
Parent or Guardian Name (print)

Parents/Guardians: STOP here. The rest of this is form is completed when the camper arrives at camp.

Name of Camper ____
Birth date _______/ ______/ ______Age _______

Individual Health Record
(For Camp Use Only)

Date: **Time:** **Initials:**

Screening has been conducted according to camp protocol and significant findings noted as follows:

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

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

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: