Record of Health Exam by Licensed Medical Personnel

To be filled out by Physician

Medical Form

▶ **Please scan or take a legible photo of this completed form and upload to your Camp Docs account**

Record of Health Exam by Licensed Medical Personnel To be filled out by Physician

Date of last examination: ____________________

In my opinion, the above applicant ☐ is ☐ is not able to participate in an active camp program.

BP: ____________ WEIGHT: ____________ HEIGHT: ____________

The applicant is under the care of a physician for the following conditions:

____

____

Medications Being Taken

Please list all prescription drugs taken routinely. Keep in original packaging/bottle that identifies the prescribing physician, name of medication, dosage, and frequency of administration.

☐ This person takes no medications on a routine basis.

☐ This person takes medication as follows:

MED #1: ____________ DOSAGE: ____________

REASON: ____________

MED #2: ____________ DOSAGE: ____________

REASON: ____________

MED #3: ____________ DOSAGE: ____________

REASON: ____________

Please identify any medications taken during school year only: ____________

____

Recommendations and Restrictions at Camp

Treatment to be continued at camp: ____________

Dietary restrictions including lactose intolerance: ____________

Allergies: ____________

Any limitations or restrictions of camp activities: ____________

Campers will not be admitted to camp without a health form signed by licensed medical personnel.

SIGNATURE OF LICENSED MEDICAL PERSONNEL: ____________

PRINTED NAME: ____________ TITLE: ____________

ADDRESS: ____________

PHONE: (   ) ____________ DATE: ____________

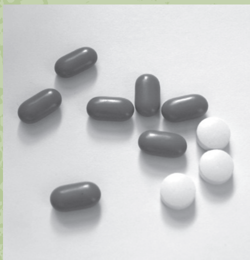
FAX: (   ) ____________ EMAIL: ____________

PO Box 577, Ivoryton, CT 06442
info@incarnationcamp.org
Phone: 860.767.0848
Fax: 860.357.6131

Authorization for Non-Prescription Drug Administration

To be filled out by Parent/Guardian and Physician

Please scan or take a legible photo of this completed form and upload to your Camp Docs account



There may be times at camp when your child will ask for non-prescription medications to help relieve symptoms related to minor conditions such as poison ivy, headache, or upset stomach. A Registered Nurse (RN) at the Health Center can assess the camper's condition and dispense the appropriate medications. For campers who do not have ready access to an RN, we have staff who have received special instructions and training on the administration of selected non-prescription drugs and who are competent to do so or to assist the camper with self-administration. Campers in Pioneer Village or those away from camp on a trip are examples of those who may need the assistance of these trained staff members.

The state of Connecticut has set new regulations governing the terms and conditions under which these staff members may act. Specifically, the parent or guardian must indicate in writing which of the available non-prescription drugs may be used or given. In addition, the camper's physician must concur in writing with your decisions. The camp physician has approved the non-prescription drugs listed below for use at camp and we will have these in stock. Please indicate which drugs you do or do not want your child to have when needed. **Your physician must then do the same.**

CAMPER'S LAST NAME: FIRST: MIDDLE:

ADDRESS:

CITY: STATE: ZIP CODE:

	Parent/Guardian		Physician	
	MAY GIVE	MAY NOT GIVE	MAY GIVE	MAY NOT GIVE
Topical				
Calamine or caladryl lotion hydrocortisone 1% cream	☐	☐	☐	☐
Hydrogen peroxide	☐	☐	☐	☐
Kenalog cream	☐	☐	☐	☐
Lidocaine topical ointment	☐	☐	☐	☐
NIX crème rinse	☐	☐	☐	☐
Normal saline solution	☐	☐	☐	☐
Proxigel or similar canker sore medication	☐	☐	☐	☐
Silvadene Cream	☐	☐	☐	☐
Tinactin or similar antifungal powder, spray, or cream	☐	☐	☐	☐
Triple antibiotic ointment	☐	☐	☐	☐
Eardrops				
Debrox	☐	☐	☐	☐
Swimmer's Drops (½ vinegar, ½ alcohol)	☐	☐	☐	☐
Oral				
Benadryl (diphenhydramine)	☐	☐	☐	☐
Chloroseptic spray or lozenges	☐	☐	☐	☐
ChlorTrimeton (allergy, decongestant)	☐	☐	☐	☐
Dimetapp (decongestant)	☐	☐	☐	☐
Kaopectate	☐	☐	☐	☐
Maalox	☐	☐	☐	☐
Milk of magnesia	☐	☐	☐	☐
Motrin (Ibrubrofen)	☐	☐	☐	☐
Pepto-Bismol (bismuth subsalicylate)	☐	☐	☐	☐
Robitussin DM (cough suppressant)	☐	☐	☐	☐
Sudafed (pseudoephedrine)	☐	☐	☐	☐
Tums (calcium carbonate)	☐	☐	☐	☐
Tylenol (acetaminophen)	☐	☐	☐	☐
Other	☐	☐	☐	☐

We give permission for a Registered Nurse or Staff Member trained in accordance with the State of Connecticut Health Department regulations to administer medications as indicated above in accordance with the label directions and with attention to the relevant side effects also listed on the label of above medications.

SIGNATURE OF PARENT/GUARDIAN: DATE:

SIGNATURE OF PHYSICIAN: DATE:

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Permission for Self-Administration of Medication
(if necessary)

A camper with a chronic disease or medical condition may possess and self-administer prescribed medication for the disease or condition if the camper's parent/guardian has filed a written authorization with the camp nurse. The written authorization must be filed annually and must include the following information.

1. A physician's statement that the camper has an acute or chronic disease or medical condition for which medication has been prescribed.
2. The nature of the disease or medical condition requiring emergency administration of the prescribed medication.
3. The camper has been instructed in how to self-administer the prescribed medication.
4. The camper is authorized to possess and self-administer the prescribed medication by the parent/guardian.

This form is only for campers who must keep epi-pens or other emergency medications on their person.

CAMPER LAST NAME: FIRST:

DATE OF BIRTH: / / AGE AT CAMP:

MEDICAL CONDITION:

DRUG ALLERGIES:

MEDICATION:

DOSAGE/TIME INTERVAL:

☐ The Camper has been instructed on how to self-administer and is authorized as signed below to self-administer the prescribed medication.

SIGNATURE OF PHYSICIAN: DATE:

PRINTED NAME:

Parent/guardian accepts legal responsibility for the safe transport of the student's medication to and from camp. The camp nurse may contact the camper's physician if there are questions regarding the use of this medication. It is the responsibility of the parent/guardian to maintain a supply of the medication for the camper.

SIGNATURE OF PARENT/GUARDIAN: DATE:

PRINTED NAME: DATE:

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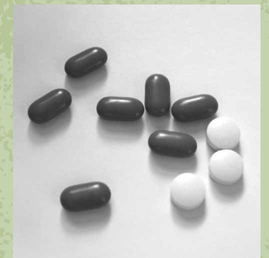

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