



HEALTH RECORD

MUST BE FILLED OUT BY PARENT/GUARDIAN IN ADDITION TO SUBMIT COPIES OF LATEST PHYSICAL EXAMINATION, SUPPLEMENTS, VACCINATIONS, and INSURANCE CARD

Camp: _____

Camper Name: _____
Last First M.I.

DOB: ____/____/____ Gender _____ Age while in camp: _____

Parent/Guardian:

Name _____ Relation to Child: _____
Last First

Address: _____
Street Town/City State Zip

Phone (Day): (____) _____ - _____ Phone (Evening): (____) _____ - _____

Health History: Provide dates and other information requested or indicate N/A.

Ear Infections _____	Chicken Pox _____	Measles _____
Convulsions _____	German Measles _____	Diabetes _____
Mumps _____	Bleeding Disorder _____	Tuberculosis _____

Allergies: _____

Operations/serious injuries: _____

Disability or chronic or recurring illness: _____

Current medications _____

Name of dentist/orthodontist: _____ Phone # _____

Name of physician: _____ Phone # _____

Signature of Parent/Guardian: _____ **Date:** _____

***IMPORTANT: Please attach a copy of Health Insurance Card (front and back)**

IMMUNIZATIONS: THIS SECTION MUST BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER OR ATTACH A COPY OF IMMUNIZATION DOCUMENTATION OR ALTERNATIVE PROOF OF IMMUNITY.

REQUIRED IMMUNIZATIONS (Campers under 18)	DATE (Month/Day/Year)
MMR (1 st dose age 12 months or older)	
Measles #2 or MMR #2 (Given at age 4-6)	
Polio (3 doses of OPV or IPV or 4 doses of mix IPV or OPV)	#1 #2 #3 #4
Diphtheria and Tetanus Toxoids and Pertussis	#1 #2 #3 #4 Booster (if applicable)
Hepatitis B (3 doses if born on or after January 1, 1982)	#1 #2 #3

LEAD SCREENING: _____

Effective 3/01/90 Massachusetts State Law requires all children, regardless of risk, to be screened at least once between ages of 9-12 months and annually until the age of 48 months. Children under 3 years who are determined to be at high risk for lead exposure must be screened every 6 months, and yearly from 3 years to 6 years. Children must present evidence of having been previously screened as a condition for entry to kindergarten.

Physical examination by a physician: This section must be completed by a physician or attach a copy of a physical examination conducted by a medical provider during the preceding 24 months.

Height:	Eyes:	Abdomen:
Weight:	Vision:	Genitalia, Hernia:
BP:	Ears, Nose, Throat:	Musculoskeletal:
HCT or Hgb:	Heart:	Neurological Exam:
Urinalysis:	Lungs:	Skin:

DATE OF LAST PHYSICAL EXAM: _____

Recommendation for camp participation:

- Is person capable of participating in active camp programs?

YES
NO

- Please explain any restrictions _____

- Is person currently taking medications? _____

- List any medications to be administered by Camp Health Supervisor:

Signature of Health Care Provider: _____ **Date:** _____

Printed Name of Health Care Provider: _____

Office Address: _____ **Phone:** _____

***Important Required Health Record Document Checklist:**

___ 1. Copy of latest physical examination conducted by a physician or medical provider during the preceding 24 months

___ 2. Copy of immunization records is attached

___ 3. Completed forms, and/or attached supplemental documentation

___ 4. Complete and Sign the Authorization to Administer Medication form on the next page regardless if camper is on any specific medication or not. If no medication simply use N/A

___ 5. Copy of the campers Health Insurance Card (front and back)

AUTHORIZATION TO ADMINISTER MEDICATION TO A CAMPER

Required Information to be completed by parent/guardian – Please Print



AUTHORIZATION TO ADMINISTER MEDICATION TO A CAMPER

Required Information to be completed by parent/guardian – Please Print

This forms only needs to be filled out if the camper needs to take medication during their time at camp

Camp name: _____ Name of camper: _____

DOB: _____ Parent/guardian name: _____

Home telephone: _____ Work telephone: _____

Emergency contact: _____ Emergency telephone: _____

Food/drug allergies: _____

Does the camper take any prescription medication? Yes No

Diagnosis (at parent's discretion): _____

Name of licensed prescriber: _____

Name of medication: _____ Dose to be given during camp: _____

How to administer: _____ Frequency: _____

Date ordered: _____ Duration of order: _____

Quantity received: _____ Expiration date: _____

Special storage requirements: _____

Specific directions (e.g. on an empty stomach): _____

Specific precautions: _____

Possible side effects/reactions: _____

Other medications (at parent's discretion): _____

Location where medication administration will occur: _____



AUTHORIZATION TO ADMINISTER MEDICATION TO A CAMPER (CON'T)

I hereby authorize Springfield College's Health Care staff to administer to my child (please print first and last name, _____), the medication(s) listed above, in accordance with 105 CMR 430.160. (Minimum standards for recreational Camps for Children)

430.160: Storage and Administration of Medication

(A) Medication prescribed for student 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 student shall be kept in the original containers containing the original label, which shall include the directions for use.

(B) All medication prescribed for student shall be kept in a locked storage cabinet used exclusively for medication, which is kept locked except when opened to obtain medication. The cabinet shall be substantially constructed and anchored securely to a solid surface. Medications requiring refrigeration shall be stored at temperatures of 38° to 42°F in a locked box, used exclusively for medications, and physically affixed to the refrigerator.

(C) Medication shall only be administered by the health supervisor or by a licensed health care professional authorized to administer prescription medications. 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. The health care consultant shall acknowledge in writing a list of all medications administered at the camp. 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.

(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 as follows:

(1) Destruction of prescription medication shall be accomplished by the health care consultant, witnessed by a second person and recorded in a log maintained by the camp for this purpose. Said log shall include the name of the camper, the name of the medication, the quantity of the medication destroyed, and the date and method of destruction. The health care consultant and the witness shall sign each entry in the medication destruction log.

(2) The medication log shall be maintained for at least three years following the date of the last entry.

430.159: Health Care Staff to be provided

(C) A health supervisor, who is at least 18 years of age, is present at the workshop at all times. The health supervisor shall be a Massachusetts licensed physician, physician assistant, nurse practitioner, registered nurse, licensed practical nurse, or other person specially trained in first aid. First aid training shall mean at least current certification in American Red Cross Standard First Aid, or its equivalent and CPR. Primitive, Travel, and Trip Camps shall have at least one individual in addition to the health supervisor accompanying the students, who is adequately trained to render first aid. Said individual shall possess at least current certification in Red Cross Standard First Aid, or its equivalent.

Parent/Guardian Name: _____

(please print)

Parent/Guardian Signature: _____

Date: _____



PARENT/GUARDIAN AUTHORIZATION

Camp Name: _____

Camper Name: _____
Last Name First Name

Authorization to Participate/Assumption of Risk: I understand and certify that my child's participation at Springfield College and its activities is completely voluntary and I have familiarized myself with the program and activities in which my camper will be participating. I recognize that certain hazards and dangers are inherent within the program. I acknowledge that although Springfield College has taken safety measures to minimize the risk of injury to participants, Springfield College cannot insure nor guarantee that the participants, equipment, premises, and/or activities will be free of hazards, accidents, and/or injuries. I further recognize and have instructed my camper in the importance of knowing and abiding by the camp's rules, regulations, and procedures for the safety of camp participants. If camp rules are not followed, my camper may be sent home.

Parent/Guardian:
SIGNATURE _____ DATE _____

Health Record Authorization: The health history for my camper is correct, and he/she has my permission to engage in all camp activities except as noted by me and/or the examining physician. This form may be shared with the Health Department. I also give permission for my camper's medical records to be photocopied for Health Department Records.

Parent/Guardian:
SIGNATURE _____ DATE _____

Emergency Authorization: I hereby give permission to the physician selected by a representative of Springfield College to order x-rays, routine tests, and treatment for the health of my camper. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by a representative of Springfield College to hospitalize, charge my health insurance, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my camper as named above.

Parent/Guardian
SIGNATURE _____ DATE _____

Print Name: _____
WITNESS
SIGNATURE _____ DATE _____

Print Name: _____

This form must be witnessed at the time of signing by another individual. If, for religious reasons, you cannot sign this form, contact us for a legal waiver, which must be signed to allow attendance.



CAMPER PICK UP AUTHORIZATION

CAMP NAME: _____

CAMPER NAME: _____
Last Name First Name

The camp staff **will not** release a camper to anyone not listed on this release form, which must be signed by a parent/guardian.

Until staff members are able to recognize you and the people who will be picking up your camper, staff may ask for a picture identification, which will be cross referenced with the information submitted on this form. This is the only way that we can be certain that we are releasing your camper to the appropriate individual(s).

If a person's name does not appear on this form, the camper will not be released. *A note may be sent in with your camper on a day a new individual picks camper up. Please advise anyone picking up your camper of this policy and our photo identification requirement.*

Please remember to include yourself in the list of individuals when you complete this form.

The following people have permission to pick up my camper are:

PRINT FIRST NAME, LAST NAME

PRINT RELATIONSHIP TO CAMPER:

Parent/Guardian Name: _____
(PLEASE PRINT)

Parent/ Guardian Signature: _____ Date: _____

THIS FORM IS NOT VAILD UNLESS SIGNED