SUMMER CAMP MEDICAL FORMS

INSTRUCTIONS: A parent/guardian must complete this form for the camper. If your camper has any special conditions, needs, or limitations, you must speak with the Camp Director before registering into the camp program. Non-disclosure may result in dismissal from the program without refund.

ADDITIONAL REQUIRED DOCUMENT

- ☐ Copy of physical (must have been completed within the last 12 months)
- ☐ Copy of immunization record (must be current within the last 12 months)

CAMPER INFORMATION

NAME:_____DATE OF BIRTH:_____CAMP:_____
HOME ADDRESS:_____CITY:_____STATE:____ZIP:_____

EMERGENCY CONTACT #1:_____RELATIONSHIP TO ATHLETE:_____

HOME PHONE#:_____CELL PHONE#:_____

EMERGENCY CONTACT #2_____RELATIONSHIP TO ATHLETE:_____

HOME PHONE#:_____CELL PHONE#:_____

HEALTH CARE PROVIDER

PRIMARY CARE PHYSICIAN:_____OFFICE PHONE #:_____

HEALTH INSURANCE

CARRIER/PLAN NAME:_____PHONE #:_____

GROUP:_____ID:_____POLICY:_____

POLICY SUBSCRIBER:_____REALTIONSHIP TO CAMPER:_____

RESTRICTIONS

Camp activities are similar to those described in the newsletter, camp brochure or information packet.

- ☐ I have reviewed the Camp's program/activities and feel the camper can participate without restrictions
- ☐ I have reviewed the Camp's program/activities and feel the camp can participate with the following restritctions:_____

HEALTH HISTORY

Check box if applicable and use line to explain

- ☐ Allergies:_____
- ☐ Asthma:_____
- ☐ Bleeding/Clotting Disorder:_____
- ☐ Diabetes:_____
- ☐ Dietary Restrictions:_____
- ☐ Chronic Illness:_____
- ☐ Heart Defect/Disease:_____
- ☐ Hyper/Hypotension:_____
- ☐ Mononucleosis:_____
- ☐ Operations:_____
- ☐ Injuries:_____
- ☐ Seizure Disorder:_____
- ☐ Mental Illness:_____
- ☐ Hearing Impairment:_____
- ☐ Vision Impairment:_____
- ☐ Other:_____

_____

_____

MEDICATIONS

☐ This camper will not bring any medications to camp

Include any medication that the camper may need to take at camp, including over-the-counter medications. If the camper will participate in an overnight, include evening or early morning medications. The camper's parent/ guardian must supply these medications, labeled with the camper's name, unexpired and in original containers, and bearing specific directions for administering. Prescription medications must have the full pharmacy label.

☐ This camper will bring the following medications to camp
(Please include inhalers/epi-pens/etc. in this section)

MEDICATION	AMOUNT/DOSE	INSTRUCTIONS	REASON FOR TAKING

☐ This camper is allowed to be administered the following medications by the camp's Athletic Trainer when deemed necessary (please be aware these are typically generic versions of these medications)

☐ TYLENOL ☐MOTRIN/ADVIL ☐ANTACID ☐BENADRYL ☐PEPTO-BISMOL

WAIVER/ AUTHORIZATION

Medical Release: This health history is correct and accurately reflects the known health status of the named camper. The camper described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to camp staff to provide routine health care; to administer prescribed or over-the-counter medications as described; and to provide or obtain emergency care and transportation for the camper if needed. I give permission to the physician selected by the camp to order x-rays, tests, and treatment related to the health of my child both for routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order and administer medication, injection, anesthesia, X-rays, special procedures, or surgery for this child, if deemed medically necessary. I understand that I am responsible for the cost of any medical care or prescriptions my child requires. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I understand that information on this form will be shared on a "need to know" basis with camp staff.

Medications: Pursuant to Massachusetts law and Holy Cross policy, I authorize Holy Cross' designated healthcare staff to administer as listed above Medications at Camp and Asthma or Allergy Emergency Medications, as directed, to my child for whom it was prescribed. I understand that all medications at camp must be approved by the camp's off-site healthcare consultant, seen and checked by the camp's health supervisor, and each dose monitored by a camp staff member. I understand that all medications must be in their original containers, unexpired, and labeled with specific instructions, including the child's name and dosage, and that any prescription medications must include the full pharmacy label.

Insurance: I certify that the named camper is covered by health and accident insurance or Medicaid and that the policy information given is correct.

I, the parent/legal guardian of the named camper, have read, understand and agree to the above.

SIGNATURE:_____**DATE:**_____

PRINT NAME:_____**RELATIONSHIP TO CAMPER:**_____