


**SAUU and Arts & Rec 2018 – Camper Emergency and Health Record**

Child Name: \_\_\_\_\_  
LAST FIRST MIDDLE I.

Date of Birth: \_\_\_\_\_ Gender: M  F  Age: \_\_\_\_\_ Grade (2018/19 SY): \_\_\_\_\_

Home Address: \_\_\_\_\_  
STREET NAME CITY STATE ZIP

Camp Dates	Camp Options		
<input type="checkbox"/> Week 1: July 9 – 13	Half-Day <input type="checkbox"/>	Full-Day <input type="checkbox"/>	Arts & Rec <input type="checkbox"/>
<input type="checkbox"/> Week 2: July 16 – 20	Half-Day <input type="checkbox"/>	Full-Day <input type="checkbox"/>	Arts & Rec <input type="checkbox"/>
<input type="checkbox"/> Week 3: July 23 – 27	Half-Day <input type="checkbox"/>	Full-Day <input type="checkbox"/>	Arts & Rec <input type="checkbox"/>
<input type="checkbox"/> Week 4: July 30 – August 3	Half-Day <input type="checkbox"/>	Full-Day <input type="checkbox"/>	Arts & Rec <input type="checkbox"/>
<input type="checkbox"/> Week 5: August 6 – 10	Half-Day <input type="checkbox"/>	Full-Day <input type="checkbox"/>	Arts & Rec <input type="checkbox"/>
<input type="checkbox"/> Week 6: August 13 – 17	Half-Day <input type="checkbox"/>	Full-Day <input type="checkbox"/>	Arts & Rec <input type="checkbox"/>



**First Parent/Guardian**

Name: \_\_\_\_\_  
 Address (if different from above): \_\_\_\_\_  
 Phone Number(s) Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

**Second Parent/Guardian**

Name: \_\_\_\_\_  
 Address (if different from above): \_\_\_\_\_  
 Phone Number(s) Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

If the above parent/guardian is not available in an emergency, please notify:

Name: \_\_\_\_\_  
 Relationship: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone Number(s) Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Will the parent(s) or guardian(s) named above be traveling domestically or abroad while the child is attending SAUU or Arts&Rec? Yes  No

If **YES**, please include location and telephone number where the parent/guardian can be reached below:

Location/Address: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_

**HEALTH INFORMATION**

Child Name: \_\_\_\_\_

Name of family physician \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

**MEDICAL HISTORY** – Does the child have any medical conditions, impairments, or injuries that we should be aware of? If yes, please give a detailed description including restrictions, if any:

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**ALLERGIES** – Please list all known.

*\*If your child has a severe, life-threatening allergy (requires an epipen) please provide us with an Emergency Health Care Plan signed by yourself and a physician. We recommend that you attach a photo of your child to your Emergency Plan.*

Medication allergies (list) \_\_\_\_\_

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Food allergies (list) \_\_\_\_\_

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Other allergies (list) – include insect stings, hay fever, animal dander, etc. \_\_\_\_\_

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## MEDICAL RELEASE

Child Name: \_\_\_\_\_

**Parent/Guardian Authorization:** I hereby give permission to the medical personnel selected by the program director to order x-rays, routine tests, treatment, and to provide or arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to medical personnel selected by the program director to secure and administer treatment, including hospitalization, for the person named above. I understand the “mildly ill child policy” and agree to its terms. This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**\*PLEASE INCLUDE A COPY OF YOUR CHILD’S IMMUNIZATION RECORDS AS WELL AS A SIGNED & DATED PHYSICAL EXAM LETTER FROM YOUR DOCTOR\***

## MEDICATIONS

Please mark the statement that applies to your camper.

- Child takes NO medication or is NOT prescribed any medications.
- Child takes daily medications or routinely takes medications (prescribed OR over the counter).

(If checked, fill out and sign **Authorization to Administer Medication to a Camper** form - **page 4\***).

\*Please list ALL medications (including over-the-counter or non-prescription drugs) taken routinely. Please have your child bring enough medications to last the entire time at camp. Keep medications in the original packaging/bottle that identifies the prescribing physician, the name of the medication, the dosage and the frequency of administration.



**AUTHORIZATION TO ADMINISTER MEDICATION TO A CAMPER**

(To be completed by parent/guardian)

Child Name: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

- a. Medication taken at home ONLY
- b. Medication to be given at camp on as needed basis (i.e. Tylenol, Benadryl, Ibuprofen, Inhaler) or in the event of an emergency (i.e. Epipen)

If box B above is checked, continue:

Dose to be given at camp: \_\_\_\_\_ Route of Administration: \_\_\_\_\_

Frequency: \_\_\_\_\_ Quantity Received: \_\_\_\_\_

Expiration Date of Medications Received: \_\_\_\_\_ Special Storage Requirements: \_\_\_\_\_

Specific Directions (e.g. on empty stomach/with water): \_\_\_\_\_

Possible Side Effects/Adverse Reactions: \_\_\_\_\_

Other medications (at parents' discretion): \_\_\_\_\_

*\*Attach prescription/medication requirements or medication administration details if necessary.*

I hereby authorize **SAUU** to administer, to my child, \_\_\_\_\_ the medication(s) listed above, in accordance with 105 CMR 430.160. (NAME OF CHILLD)

105 CMR 430.160(A)

*Medication prescribed for campers 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 campers shall be kept in the original containers containing the original label, which shall include the directions for use.*

105 CMR 430.160(C)

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

105 CMR 430.160(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.*

\*Health Supervisor – A person who is at least 18 years of age, specially trained and certified in at least current American Red Cross First Aid (or its equivalent) and CPR, has been trained in the administration of medications and is under the professional oversight of a licensed health care professional authorized to administer prescription medications.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_