THE UMBRELLA
COMMUNITY ARTS CENTER

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

Child Name:_____
LAST FIRST MIDDLE I.

Date of Birth: _____Age: _____

Home Address: _____

Camp Week(s) _____ Camp Dates:_____

Half-Day ☐ Full-Day ☐ Arts & Rec ☐

Parent/Guardian #1
Name:
Address (if different from above):
Phone Number(s) Home:_____Cell:_____Work:_____

Parent/Guardian #2
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:_____

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HEALTH INFORMATION

Child Name: _____

Name of family physician_____
Address_____
Phone Number_____

MEDICAL HISTORY – Does/Did 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:

_____
_____
_____
_____
_____
_____

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) _____
_____
_____

Food allergies (list) _____
_____
_____

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

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.

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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 CHIILD)

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: _____