Health Form
Parent/Guardian Authorization, Release & Indemnity Waiver

Camper Name _____ Program(s) _____

Session(s) at Camp _____

Camper Information

Camper Name _____

Birth Date __ / __ / __ Age ____ Gender M / F
Month Day Year

Street _____

City _____ State _____ Zip _____

Parent/Guardian 1_____

Home(__) _____ Work(__) _____ Cell(__) _____

Parent/Guardian 2_____

Home(__) _____ Work(__) _____ Cell(__) _____

Emergency Contact_____

Home(__) _____ Work(__) _____ Cell(__) _____

Please indicate if your child has had any of the following injuries, conditions, or illnesses:

- ☐ Asthma
- ☐ Frequent Ear Infections
- ☐ Seizure Disorder
- ☐ Diabetes
- ☐ GI Disorders
- ☐ Heart Problems
- ☐ ADD/ADHD
- ☐ Muscular/ Skeletal Injury
- ☐ Sleepwalking
- ☐ Psychiatric Diagnosis
- ☐ Other _____

_____

Please record information about any items above; any significant medical history; any hospitalization, doctor visits or surgical history of consequence in the past 5 years; and any other health related information or further suggestions for camp personnel (attach additional information if necessary)

_____

_____

Vegetarian? Yes / No

Any Other Dietary Concerns?

_____

_____

Camper Name _____

To ensure a faster Check-In please return this form prior to camp

Please Double Check The Following:

- **Parent/Guardian Signatures Pages 2 & 4**
- **Doctor's Signature Page 3**
- **Necessary Medication Authorization Form(s)**
- **Copy of Insurance Cards Attached (front & back)**

Allergies

List ALL Known
(describe usual reaction and treatment)

Allergy _____

_____

Reaction _____

_____

_____

Treatment _____

_____

_____

Camp Jewell YMCA
Phone 860 379 2782
Fax 860 379 8715
PO Box 8, Colebrook CT 06021
www.campjewellymca.org

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PO Box 8 Colebrook CT 06021

Camper Name _____

This Section to be completed by a Parent/Guardian

To my knowledge, this health history is correct, and the person herein described has permission to engage in all camp activities except as noted.

Authorization for Treatment: I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment, and necessary transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above. This completed form may be photocopied for trips out of camp. I also give permission for routine medical care as per the camp physician's standing orders for my child at Camp Jewell YMCA. I understand the camp fees do not include health and accident insurance and I will be responsible for any and all charges incurred in obtaining prompt medical attention.

Signature of parent or guardian_____ Date_____

During Resident & Day camp programs, the following medications are kept in stock and are used to treat minor symptoms of illness/injury. They are administered by a Registered Nurse or Licensed Practical Nurse according to the Standing Orders of our Camp Physician. Please CROSS OUT any medications listed below that you do NOT want to be administered.

- Acetaminophen (Tylenol)
- Allegra (Fexofenadine)
- Anatacids
- Bacitracin/Antibiotic Cream
- Benadryl/Diphenhydramine
- Betadine
- Caladryl/Calagel
- Calamine Lotion
- Cetirizine/Zyrtec
- Claritin/Loratadine
- Cough Drops
- Epipen
- Eye Drops
- Eyewash
- Gas X (Simethicone)
- Hydrocortisone
- Hydrogen Peroxide
- Ibuprofen (Advil/Motrin)
- Kaopectate
- Lice Shampoo
- Lotrimin/Antifungal Cream
- Maalox (ALUMINUM HYDROXIDE; MAGNESIUM HYDROXIDE; SIMETHICONE)
- Miralax (Polyethylene Glycol)
- Natural Tears
- Oragel (benzocaine oropharyngeal)
- Oragel
- Pepto-Bismol (Bismuth subsalicylate)
- Robitussin (dextromethorphan / guaifenesin)
- Sudafed (pseudoephedrine hydrochloride)
- Sun Burn Spray
- Sun Screen
- Throat Lozenges
- Zinc Oxide

Medication Authorization :

I hereby give permission to Camp Jewell YMCA medical personnel to administer any of the above medications or their generic equivalents not crossed out per the directions of the Camp Physician.

Signature of parent or guardian_____ Date_____

When Bringing Medication to Camp:

Connecticut State Law now requires an authorized prescriber's (M.D., Dentist, P.A., A.P.R.N.) written order AND parent or guardian's authorization for a nurse or camp personnel with current Medication Administration Training to administer medications brought from home. Prescription medications must be in the pharmacy prepared containers and labeled with the name of the child, name of the drug, strength, dosage, frequency, authorized prescriber's name and date of the original prescription. Over-the-counter medication must be in the original container and labeled with the child's name.

You MUST have one Medication Authorization Form for EACH prescription or over-the-counter medication you send with your child to camp.

A Doctor MUST Sign the Medication Authorization Form even for over-the-counter medications including vitamins and herbal supplements.

The Medication Authorization Form is available on our website www.campjewellymca.org on the form downloads page

Name of Primary Physician _____ Phone (__) _____

Name of Dentist/Orthodontist _____ Phone (__) _____

Camper Name _____

Immunization History (must be completed by parent or physician's office)

You may also attach a copy of your campers' immunization form or a copy of his/her medical/religious vaccination exemption form.

Vaccines			Year of Original Immunization	Year of Last Booster
Chickenpox	Yes	No	_____	_____
Diptheria	Yes	No	_____	_____
Hepatitis B	Yes	No	_____	_____
Measles	Yes	No	_____	_____
Mumps	Yes	No	_____	_____
Pertussis	Yes	No	_____	_____
Polio	Yes	No	_____	_____
Rubella	Yes	No	_____	_____
Tetanus	Yes	No	_____	_____
HIB-haemophilus influenza b	Yes	No	_____	_____
PCP-Pneumococcal conjugate	Yes	No	_____	_____
Covid-19	Yes	No	_____	_____

This Section to be completed by a Licensed Health Care Provider

Have your health care provider use this form, OR attach his/her own form, OR attach a signed copy of school/camp/or sports physical dated not more than 24 months before your camper's last day at camp.

I examined the above camp applicant on this date ____/____/____ *Month Day Year*

Exam must be within 24 months prior to last day of attendance at camp

☐ In my opinion the condition of the camp applicant ALLOWS for the participation in an active camp program.

☐ In my opinion the condition of the camp applicant DOES NOT ALLOW for the participation in an active camp program.

Has the camp applicant been treated for any of the following:

Yes	No	Condition	Explain
__	__	ADHD/ADD	_____
__	__	Allergies	_____
__	__	Asthma	_____
__	__	Bladder Problems/Bedwetting	_____
__	__	Bleeding Disorders	_____
__	__	Concussion	_____
__	__	Dental Braces	_____
__	__	Diabetes	_____
__	__	Ear/Sinus Problems	_____
__	__	Fainting	_____
__	__	GI Problems/Constipation	_____
__	__	Hearing/Speech Problems	_____
__	__	Heart Problems	_____
__	__	High Blood Pressure	_____
__	__	Learning Disorders	_____
__	__	Menstrual Problems	_____
__	__	Seizures	_____
__	__	Sleeping Problems	_____
__	__	Vision Problems / Glasses	_____

Licensed Health Care Provider's Signature

_____

Print Name of Health Care Provider

_____

Health Care Provider's Address

_____

City _____State____ Zip ____

Telephone

_____

Fax

_____