

Record of Health Exam by Licensed Medical Personnel

To be filled out by Physician

Medical Form



► Please scan or take a legible photo of this completed form and upload to your Campbrain registration account at

<http://incarnationcamp.campbrainregistration.com>



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Phone: 860.767.0848
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Record of Health Exam by Licensed Medical Personnel To be filled out by Physician

Date of last examination: _____

In my opinion, the above applicant is is not able to participate in an active camp program.

BP: _____ WEIGHT: _____ HEIGHT: _____

The applicant is under the care of a physician for the following conditions:

Medications Being Taken

Please list all prescription drugs taken routinely. Keep in original packaging/bottle that identifies the prescribing physician, name of medication, dosage, and frequency of administration.

- This person takes no medications on a routine basis.
 This person takes medication as follows:

MED #1: _____ **DOSAGE:** _____

REASON: _____

MED #2: _____ **DOSAGE:** _____

REASON: _____

MED #3: _____ **DOSAGE:** _____

REASON: _____

Please identify any medications taken during school year only:

Recommendations and Restrictions at Camp

Treatment to be continued at camp: _____

Dietary restrictions including lactose intolerance: _____

Allergies: _____

Any limitations or restrictions of camp activities: _____

Campers will not be admitted to camp without a health form signed by licensed medical personnel.

SIGNATURE OF LICENSED MEDICAL PERSONNEL:

PRINTED NAME: _____ TITLE: _____

ADDRESS: _____

PHONE: () _____ DATE: _____

FAX: () _____ EMAIL: _____

Authorization for Non-Prescription Drug Administration

To be filled out by Parent/Guardian and Physician

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There may be times at camp when your child will ask for non-prescription medications to help relieve symptoms related to minor conditions such as poison ivy, headache, or upset stomach. A Registered Nurse (RN) at the Health Center can assess the camper's condition and dispense the appropriate medications. For campers who do not have ready access to an RN, we have staff who have received special instructions and training on the administration of selected non-prescription drugs and who are competent to do so or to assist the camper with self-administration. Campers in Pioneer Village or those away from camp on a trip are examples of those who may need the assistance of these trained staff members.

The state of Connecticut has set new regulations governing the terms and conditions under which these staff members may act. Specifically, the parent or guardian must indicate in writing which of the available non-prescription drugs may be used or given. In addition, the camper's physician must concur in writing with your decisions. The camp physician has approved the non-prescription drugs listed below for use at camp and we will have these in stock. Please indicate which drugs you do or do not want your child to have when needed. **Your physician must then do the same.**

CAMPER'S LAST NAME: _____ FIRST: _____ MIDDLE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

	Parent/Guardian		Physician	
	MAY GIVE	MAY NOT GIVE	MAY GIVE	MAY NOT GIVE
Topical				
Calamine or caladryl lotion hydrocortisone 1% cream	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hydrogen peroxide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kenalog cream/spray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lidocaine topical ointment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NIX crème rinse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Normal saline solution	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Proxigel or similar canker sore medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Silvadene Cream	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tinactin or similar antifungal powder, spray, or cream	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Triple antibiotic ointment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eardrops/Eyedrops				
Debrox	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swimmer's Drops (1/2 vinegar, 1/2 alcohol)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antihistamine eye drops	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oral				
Benadryl (diphenhydramine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chloroseptic spray or lozenges	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Claritin (Loratadine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dimetapp (decongestant)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Zyrtec (Cetirizine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Milk of magnesia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Motrin (Ibuprofen)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pepto-Bismol (bismuth subsalicylate)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Robitussin DM (cough suppressant)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sudafed (pseudoephedrine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tums (calcium carbonate)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tylenol (acetaminophen)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

We give permission for a Registered Nurse or Staff Member trained in accordance with the State of Connecticut Health Department regulations to administer medications as indicated above in accordance with the label directions and with attention to the relevant side effects also listed on the label of above medications.

SIGNATURE OF PARENT/GUARDIAN: _____ **DATE:** _____

SIGNATURE OF PHYSICIAN: _____ **DATE:** _____



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Permission for Self-Administration of Medication (if necessary)

A camper with a chronic disease or medical condition may possess and self-administer prescribed medication for the disease or condition if the camper's parent/guardian has filed a written authorization with the camp nurse. The written authorization must be filed annually and must include the following information.

1. A physician's statement that the camper has an acute or chronic disease or medical condition for which medication has been prescribed.
2. The nature of the disease or medical condition requiring emergency administration of the prescribed medication.
3. The camper has been instructed in how to self-administer the prescribed medication.
4. The camper is authorized to possess and self-administer the prescribed medication by the parent/guardian.

This form is only for campers who must keep epi-pens or other emergency medications on their person.

CAMPER LAST NAME: _____ FIRST: _____

DATE OF BIRTH: / / AGE AT CAMP: _____

MEDICAL CONDITION: _____

DRUG ALLERGIES: _____

MEDICATION: _____

DOSAGE/TIME INTERVAL: _____

The Camper has been instructed on how to self-administer and is authorized as signed below to self-administer the prescribed medication.

SIGNATURE OF PHYSICIAN: _____ **DATE:** _____

PRINTED NAME: _____

Parent/guardian accepts legal responsibility for the safe transport of the student's medication to and from camp. The camp nurse may contact the camper's physician if there are questions regarding the use of this medication. It is the responsibility of the parent/guardian to maintain a supply of the medication for the camper.

SIGNATURE OF PARENT/GUARDIAN: _____ **DATE:** _____

PRINTED NAME: _____ **DATE:** _____

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