

# Bushy Hill Day Camp Health Exam/Record

## For Campers and Staff

Physical Exams are Valid for 3 Years

From Date of Last Examination

camper  staff

**Please Return Completed Form to the Camp**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Phone \_\_\_\_\_

Guardian \_\_\_\_\_ Address \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Telephone \_\_\_\_\_

Date of Arrival at Camp: \_\_\_\_\_ Departure Date: \_\_\_\_\_

.....  
**TO BE COMPLETED BY THE SPECIFIED MEDICAL PARCTITIONER:**

**Date of Exam** \_\_\_/\_\_\_/\_\_\_

\_\_\_ May participate in all camp activities

\_\_\_ May participate except for: \_\_\_\_\_

Medical information pertinent to routine care and emergencies: \_\_\_\_\_

Is this individual taking prescription or over the counter medication(s)?  YES  NO If yes, indicate names of Medication(s): \_\_\_\_\_

Does the individual have allergies?  YES  NO Explain: \_\_\_\_\_

Is the individual on a special diet?  YES  NO Explain: \_\_\_\_\_

Does the individual have special needs?  YES  NO Explain: \_\_\_\_\_

This camper/staff is up-to-date on all the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and National Advisory Committee on Immunization Practices:

	YES	NO		YES	NO
Measles			Hepatitis		
Mumps			Diphtheria		
Rubella			Pertussis		
Chickenpox			Polio		
Tetanus					

**Comments:** \_\_\_\_\_

Print name of medical care provider: \_\_\_\_\_

Medical care provider's address: \_\_\_\_\_

Medical care provider's: City/Town \_\_\_\_\_ ST \_\_\_\_\_ Zip Code \_\_\_\_\_

\_\_\_\_\_  
Signature of Physician, PA, APRN,RN

\_\_\_\_\_  
Date form signed

\_\_\_\_\_  
Telephone Number

# Authorization for the Self-Administration of Medication While Attending Programs at the Bushy Hill Nature Center

Parent/guardians requesting to be self-administered by their child while at camp shall provide the program with appropriate written authorization and the medication before any medications are administered. Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration and date of the prescription. All unused medication will be destroyed if not picked up within one week following the camper's departure at the end of camp.

**AUTHORIZED PRESCRIBER'S ORDER** (Physician, Dentist, Physician Assistant, Advanced Practice Registered Nurse):

Name of Child \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ Today's Date \_\_\_/\_\_\_/\_\_\_

Medication Name \_\_\_\_\_ Controlled Drug?  Yes  No

Dosage \_\_\_\_\_ Method \_\_\_\_\_ Time of Administration \_\_\_\_\_

## Specific Instructions for Medication Self-Administration

Medication Administration: Start Date \_\_\_/\_\_\_/\_\_\_ Stop Date \_\_\_/\_\_\_/\_\_\_

Relevant Side Effects of Medication \_\_\_\_\_

Plan of Management for Side Effects \_\_\_\_\_

Known Food or Drug: Allergies?  Yes  No Reactions to?  Yes  No NO interactions with?  Yes  No

If "yes" to any of the above, please explain \_\_\_\_\_

Prescriber's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Prescriber's Address \_\_\_\_\_ Town \_\_\_\_\_ ST \_\_\_\_\_

Prescriber's Signature \_\_\_\_\_

## Parent/Guardian Authorization:

I request that medication be self-administered by my child as described and directed above.

Name of Camp \_\_\_\_\_ Today's Date \_\_\_/\_\_\_/\_\_\_

Child's Name \_\_\_\_\_ Address \_\_\_\_\_ Town \_\_\_\_\_

Name of Parent/Guardian Authorizing Self-Administration of Medication \_\_\_\_\_

Relationship to Child:  Mother  Father  Guardian/Other explain: \_\_\_\_\_

Address \_\_\_\_\_ Town \_\_\_\_\_ Phone # \_\_\_\_\_

Signature of Parent/Guardian Authorizing Self-Administration of Medication \_\_\_\_\_

Name of Camp Personnel Receiving Written Authorization and Medication \_\_\_\_\_

Title/Position \_\_\_\_\_ Signature (in ink) \_\_\_\_\_