Unit: _____ Campsite: _____ Name: _____

REQUIRED

A current medical form is needed for every person (youth & adult) participating or staying in camp for more than 24 hours.

A new medical evaluation is required every 36 months (3 years) for individuals under 40 years of age and every 12 months (1 year) for individuals 40 and over.

All forms must be updated yearly by a parent/guardian for those under 18 or by the participant if 18 or over.

SECTION A: Personal Information & Health History (To be filled out by participant/parent or guardian)

Camper's Name: _____ Sex M/F
Last First

Address: _____

Town: _____ ST: _____ Zip:_____ Age: _____ D.O.B. _____

Telephone Contact for Parent/Guardian:
(Home) _____ (Work) _____ (Cell) _____

Emergency Contact_____
(Other than parent or guardian)
Address: _____
Telephone:
(Home)_____ (Work)_____ (Relation) _____

Personal Physician: _____ Phone: _____

Address: _____

Insurance Carrier: _____ Policy Number: _____

Insurance Carrier Address: _____

HEALTH HISTORY (X)
Serious Illness___Serious Injury___
Deformity___ Surgery___
Cancer___*Other___

KNOWN ALLERGIES (X)
Animal___ Insect Toxin ___
Drug___ Foods___
Plant___ *Other___

GENERAL INFORMATION (X)
Asthma___ Seizure/Epilepsy___ Diabetes___
ADHD___ Emotional Difficulty ___
Cardiac___ Blood Pressure___
Bleeding Disorders ___ Mobility Difficulty___
Glasses/Contacts___ Denture/Orthodic___

Please list below any equipment needed at camp: wheelchairs, braces, crutches, etc.

_____

*Please explain details:

_____

_____

IMMUNIZATIONS: ***Provide Actual Date*** ("Up to Date" is not acceptable to the Connecticut Department of Public Health)

Diphtheria/Tetanus/Pertussis (DTaP) 1_____2_____3_____4_____5_____ Tetanus (Td) Booster _____
Polio (IPV or OPV *please circle)* 1_____2_____3_____4_____ Varicella 1_____2_____
Measles/Mumps/Rubella (MMR) 1)_____2_____ Hepatitis B (Hep B) 1)_____2_____3_____
Tetanus/Diptheria/Pertussis (Tdap-adolescent) Booster _____ Meningococcal (MCV4) _____
Pneumoccal (PCV) _____ Hepatitis A _____ Other _____

Please list: 1) ALL medications taken in the past 30 days **prior** to camp arrival, 2) Any physical or behavior conditions that might affect or limit participation at camp: _____

_____

Unit: _____ Campsite: _____ Name: _____

SECTION B: Physical Examination to be completed and signed by a licensed medical provider. A school medical form may be attached in place of Section B.

PROVIDERS PLEASE NOTE: Provider's signature below also authorizes administration of over the counter medications (listed in Section D) by the camp Health Officer. ***Additional signature required in Section C, if prescription medications are involved.***

*DIRECTION*S: Write in values where appropriate. Place a (X) for items examined and satisfactory, leave blank if not examined. If there are any abnormalities, please make a note below in the restriction/recommendations/ comments section. Use more paper if needed and attach to this form.

Name of Person
Examined: _____ Age:_____

Height:_____ Weight:_____ B.P.: _____/_____ Pulse:_____ Hearing: *Right*_____ *Left* _____
Vision: *Near* _____ *Far*_____ Glasses: Yes/No Contacts: Yes/No

Growth/Development: ____ Skin/Glands/Hair: ____ Ears: ____ Head/Neck/Thyroid: ____
Ears/Eyes/Nose: ____ Teeth/Tonsils: ____ Cardiovascular: ____ Respiratory: ____ Abdomen:_____
Genitourinary: ____ Genitalia: ____ Musculoskeletal: ____ Neurobehavioral: ____
Hernia:_____ Other *(specify)*: _____

Activity Restrictions/ Diet Restrictions / Comments / Medical information pertinent to routine care and emergencies:

_____

_____

_____

_____

_____

The above named person is in satisfactory condition and may engage in all camp activities **(including Hiking, Boating, Swimming, Competitive Sports, Sleeping on Ground)** except where noted above.

Printed Name of Medical Provider: _____

Office Address: _____

Phone: _____ State Licensed in: _____ License No: _____

Signature of Medical Provider: _____

Date Signed: _____

Unit: _____ Campsite: _____ Name: _____

SECTION C: Prescription Medications: (To be filled out and signed by examining physician)

PRESCRIPTION MEDICATION INFORMATION

MUST BE UPDATED EVERY YEAR

To authorize administration of prescription medications to anyone at camp, this section of the medical form must be signed by the physician. Medications WILL NOT be administered unless the Camp Health Officer is in receipt of this form. Please attach a separate sheet if necessary. Thank you.

YEAR 1: Medications currently being taken: (2009)

Medication: Dosage: Route: Time:

1)_____
Side Effects/Cautions:_____

2)_____
Side Effects/Cautions:_____

3)_____
Side Effects/Cautions:_____

- ❑ May self-administer emergency/rescue medications.

Physician signature: X_____ Date: _____

YEAR 2: Medications currently being taken: (2010)

Medication: Dosage: Route: Time:

1)_____
Side Effects/Cautions:_____

2)_____
Side Effects/Cautions:_____

3)_____
Side Effects/Cautions:_____

- ❑ May self-administer emergency/rescue medications.

Physician signature: X_____ Date: _____

YEAR 3: Medications currently being taken: (2011)

Medication: Dosage: Route: Time:

1)_____
Side Effects/Cautions:_____

2)_____
Side Effects/Cautions:_____

3)_____
Side Effects/Cautions:_____

- ❑ May self-administer emergency/rescue medications.

Physician signature: X_____ Date: _____

Unit: _____ Campsite: _____ Name: _____

SECTION D: In regards to Medications, Parent/Guardian Permission, Yearly Update – Signature Required

PLEASE CAREFULLY READ THE FOLLOWING: If you disagree with any statements here, please cross out that section and initial it. Explain your wishes in the space provided, attaching additional sheet if necessary.

- This medical form is correct so far as I know, and the person named in Section A has permission to participate in all camp activities except as noted on the reverse by me or the doctor.
- In case of accident, injury or illness while at camp, I hereby give my permission to the doctor selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery or injections of medications.
- I hereby request that the prescription medication(s) listed on the reverse, ordered by the doctor/dentist for my child, be administered by the camp's Health Officer. I understand that I must supply the camp with the prescribed medication in the original container as dispensed and properly labeled by a doctor or pharmacist and will provide no more than is appropriate for my child's camp stay. I understand that this medication will be destroyed if not picked up within one week after my child leaves camp.
- I give my permission for the camp Health Officer to administer over-the-counter medications as directed for conditions as dictated by the Camp Physician (The Connecticut Yankee Council's policy on medications at Scout camp has been formulated to comply with the National Standards of the Boy Scouts of America and the State of Connecticut Health Dept.) Over the counter medications may include: Sunscreen, topically as needed for sun exposure; Bug Repellant, topically as needed q 2-4 hrs.; Robitussin (Guifenesin), po, per weight/age dosing for cough as needed q 6 hrs.; Benadryl (Diphenhydramine), po, per weight/age dosing for rash/itch, as needed, q 4-6 hrs.; Maalox, po, per weight/age dosing for upset stomach, as needed OR Tums, po, per weight/age dosing for upset stomach, as needed; Kaopectate, po, per weight/age dosing for diarrhea, as needed q 4 hrs *(NOT more than 2consecutive doses)*; Milk of Magnesia, po per weight/age dosing for constipation, as needed q 6 hrs *(NOT more than 2 consecutive doses)*; Tylenol (Acetaminophen), po, per weight/age dosing for pain, as needed q 4-6 hrs; Motrin (Ibuprofen), po, per weight/age dosing for pain as needed q 6-8 hrs; Throat Lozenge, po, 1 tab for sore throat q 2-4 hrs, as needed; Bacitracin, topically, for wound care/infection prevention, as needed; Calamine Lotion, topically, for itch/contact dermatitis, as needed, q 1 hr; EPI Pen *(Auto Inject)* & Benadryl *(po, per weight/age dosing),* for Anaphylactic Reaction (requires transport to E.R. for medical evaluation and follow-up)

This section must be signed annually to update the form or indicate acceptance of conditions above:

Year 1 (2009)
Signature: _____
Adults over 18 sign here (Parent/Guardian signs for Camper)
Name (print): _____
Relationship: _____ Date Signed: _____
Comment: _____

Year 2 (2010)
Signature: _____
Adults over 18 sign here (Parent/Guardian signs for Camper)
Name (print): _____
Relationship: _____ Date Signed: _____
Comment: _____

Year 3 (2011)
Signature: _____
Adults over 18 sign here (Parent/Guardian signs for Camper)
Name (print): _____
Relationship: _____ Date Signed: _____
Comment: _____