Week Attending _____

☐ Camper
☐ Staff

Date of Arrival _____
Departure Date _____

CAMP CUHECA MEDICAL FORM

Fax to: 860-442-2228 Attn. Tina Cote
or
Mail to: Waterford Country School – Attn. Tina Cote – P.O. Box 408 – Quaker Hill, CT 06375

Name _____ DOB _____ Age _____ M F

Address _____ City _____ State ____ Zip _____

Parent/Guardian _____

Parent/Guardian Address (if different than above) _____

Phone (home) _____ (work) _____

(cell) _____

Other contact in event of an emergency

Name _____ Phone _____

Physician's Name _____ Phone _____

Medical/Hospitalization Insurance _____ Policy # _____

Subscriber's Name _____ DOB _____

RECOMMENDATIONS AND RESTRICTIONS WHILE IN CAMP

In compliance with state law, you must sign a directive for medications if the nurse is to administer medication according to physician's standing orders. The following is a list of medications which we stock in our medical office. Please cross off any medications you **do not** want to be given to your child and then sign the statement at the bottom. You may substitute a medication if you send it with your child and write the medication in the space below. Prescribed medications must be brought to the camp nurse with the original pharmacy labels and I give permission for the nurse to administer the medication.

Pain Relief: Tylenol, Ibuprofen **Upset Stomach:** Calcium Carbonate
Contact Dermatitis (ex. Poison Ivy): Calamine lotion, Cortaid KI tablet upon nuclear accident
Hibiclens Cleanser Benzalkonium Wipes Bacitracin 1% Hydrocortisone Cream

Insect Repellant no more than 30% DEET **Sunscreen SPF 30 or higher**

Parent/Guardian Signature _____

EMERGENCY MEDICAL TREATMENT AUTHORIZATION

1. I give permission for my child to participate in the activities associated with Camp Cuheca.
2. I give permission to Camp Cuheca to administer first aid deemed necessary by registered camp nurse or emergency personnel. Parents will be notified immediately.

Medical Insurance: *If your child is taken to the L&M Hospital, you will be notified and expected to meet your child there. I understand that my private medical insurance is responsible for all hospital bills.*

Parent/Guardian Signature _____ Date _____

TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER

Individual's Name _____ Date of Exam_____

_____ May participate in all camp activities

_____ May participate except for: _____

_____

HEALTH HISTORY (check if it applies)

_____AIDS/ARC _____Diabetes _____Asthma _____Ear Infections

_____Epilepsy _____Tonsillitis _____Convulsions _____Tuberculosis

Other: _____

ALLERGIES (check if it applies)

_____Seasonal _____Insect Stings/Bites _____Drugs (specify)_____

_____Plants (Poison Ivy, etc.) _____Foods (specify)_____

Check (if yes, please give details)

_____Yes _____No On a special diet?

_____Yes _____No Has been exposed to communicable disease within the last 3 weeks

_____Yes _____No Presently taking medication?

Please list medications: _____

_____

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 B		
Mumps			Diphtheria		
Rubella			Pertussis		
Chicken Pox			Pneumococcal Conjugate		
Tetanus			Polio		

Print name of medical care provider: _____ Phone:_____

Medical care provider's address: _____

_____ _____

Signature of Physician, PA, APRN, or RN Date Form Signed

CAMP ENTRANCE PHYSICAL FINDINGS (to be completed by camp nurse)

Skin – Hair – Feet _____

E.N.T. _____

Current Health Problems _____

Medications _____

Comments _____

Camp Nurse_____ Date_____

Recheck for subsequent week(s) Nurse_____ Date_____

Nurse_____ Date_____