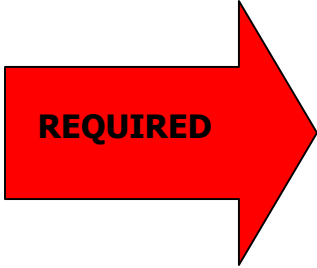


Unit: \_\_\_\_\_ Campsite: \_\_\_\_\_

Name: \_\_\_\_\_



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)	KNOWN ALLERGIES (X)	GENERAL INFORMATION (X)
Serious Illness ___ Serious Injury ___	Animal ___ Insect Toxin ___	Asthma ___ Seizure/Epilepsy ___ Diabetes ___
Deformity ___ Surgery ___	Drug ___ Foods ___	ADHD ___ Emotional Difficulty ___
Cancer ___ *Other ___	Plant ___ *Other ___	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/Diphtheria/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: \_\_\_\_\_

**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.**

**DIRECTIONS:** 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:

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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: \_\_\_\_\_

**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: (2008)

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: (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 3: 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: \_\_\_\_\_

**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 2 consecutive 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 (2008)

Signature: \_\_\_\_\_  
Adults over 18 sign here (Parent/Guardian signs for Camper)  
Name (print): \_\_\_\_\_  
Relationship: \_\_\_\_\_ Date Signed: \_\_\_\_\_  
Comment: \_\_\_\_\_

Year 2 (2009)

Signature: \_\_\_\_\_  
Adults over 18 sign here (Parent/Guardian signs for Camper)  
Name (print): \_\_\_\_\_  
Relationship: \_\_\_\_\_ Date Signed: \_\_\_\_\_  
Comment: \_\_\_\_\_

Year 3 (2010)

Signature: \_\_\_\_\_  
Adults over 18 sign here (Parent/Guardian signs for Camper)  
Name (print): \_\_\_\_\_  
Relationship: \_\_\_\_\_ Date Signed: \_\_\_\_\_  
Comment: \_\_\_\_\_