



Health Exam Form

Physical Exams must be dated within 36 months of the beginning of your camp session.
Return completed form along with immunization records to: Schooner Inc 60 S Water St New Haven, CT 06519

Name _____ Birth Date _____
Last First Middle

Home Address _____
Street Address City State Zip

Parent/Guardian Name _____ Phone _____

Home Address _____
(if different from above) Street Address City State Zip

TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER

I examined this individual on _____ and find that this individual ___ is ___ is not able to participate in this active camp program.

Medical information pertinent to outline care and emergencies: _____

Does this individual have Allergies? YES NO Explain: _____

Does this individual have a special diet/need: YES NO Explain: _____

Is this individual taking prescription or over the counter medication(s)? YES NO

If yes, indicate names of medication(s) _____

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 (circle YES or NO)

Measles	Yes	No	Hepatitis B	Yes	No
Mumps	Yes	No	Diphtheria	Yes	No
Rubello	Yes	No	Pertussis	Yes	No
Chickenpox	Yes	No	Pneumococcal Conjugate	Yes	No
Tetanus	Yes	No	Polio	Yes	No

This individual and their parent/guardian have been advised of the following limitation(s) or restriction(s) on camp activities:

Additional Comments _____

Print name of medical provider: _____

Medical care provider's address: _____
City/Town _____ ST _____ Zip Code _____

Signature of Physician, PA, APRN or RN _____ Date _____



Authorization for the Administration of Medication

In Connecticut, licensed Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the CT State Statutes and Regulations. Parents/guardians requesting medication administration to their child while at camp shall provide the program with appropriate written authorization(s) 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 shall 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 Administration _____

Medication Administration: Start Date ____/____/____ Stop Date ____/____/____

Is this medication to be self-administered by the child? Yes No

Relevant Side Effects of Medication _____

Plan of Management for Side Effects _____

Known Food or Drug Allergies? YES NO Reactions to? YES NO Interactions with? YES NO

If "yes" to any of the above, please explain _____

Prescriber's Name _____ Phone Number (____) _____

Prescriber's Address _____ Town _____

Prescriber's Signature _____

Parent/Guardian Authorization: I request that medication be administered to my child as described and directed above.

Name of Camp Schooner Inc Summer Camp: _____ Today's Date ____/____/____

Child's Name _____ Address _____ Town _____

Name of Parent/Guardian Authorizing Administration of Medication as described and directed above:

First Name _____ Last Name _____

Relationship to Child: Mother Father Guardian/Other explain: _____

Address _____ Town _____ Phone Number (____) _____

Signature of Parent/Guardian Authorizing Administration of Medication _____

Name of Camp Personnel Receiving Written Authorization and Medication _____

Title/Position _____ **Signature (in ink)** _____

Please review the Parent Packet for complete details about the Schooner Inc Medication Policy. If your child must bring medication to camp, this form is **REQUIRED** for Schooner Inc staff to be able to take the medication.



Medication Administration Record (MAR)

Name of Child _____ Date of Birth _____
 / /

Pharmacy Name _____ Prescription Number _____

Medication Order

Date	Time	Dosage	Remarks	Was This Medication Self-Administered?	Signature of Person Observing Administration
				YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	
				YES NO	

*Medication authorization form must be used as either a two-sided document or attached first and second page. This form must remain with the campers group – it must then be returned to the Camp Director.

Schooner Inc staff member - Initial below:

- ____ Authorization form is complete (other side)
- ____ Medication is appropriately labeled
- ____ Medication is in original container
- ____ Date on label is current
- ____ Medication is stored appropriately

Person Accepting Medication (print name) _____ Date ____ / ____ / 07