

Camp Spofford Medical Form

Front and Back MUST be completed and brought to Camp.
Be sure all areas are filled out and signed.

Week Attending:

Note: According to New Hampshire Regulation WS 1120.17, every participant at camp shall furnish a health history and a physician statement of health status written within two years of participation. Those 28 and under shall provide a record of immunization.

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 _____		
Date Insurance Started _____ <i>(please attach a copy of the front and back of ins. card)</i>				
Type of Policy (HMO, PPO, etc) _____				

Name:

Week Attending:

Counselors (TBA):

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 infirmary. 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

Allergic Reaction: Benadryl elixir or capsules

Upset Stomach: Antacids

Cold Symptoms: Dimetapp, Sudafed, Robitussin, Robitussin DM

Contact Dermatitis (ex. Poison Ivy): Calamine lotion, Cortaid

Over the counter medications I will be sending with my child: _____

Emergency Medical Treatment Authorization

- I give permission for my child to participate in the activities associated with the summer camping program of Camp Spofford.
- I give permission to Camp Spofford to authorize medical treatments deemed necessary by registered camp nurse, licensed physician, dentists, or emergency personnel. Parents will be notified immediately.

Medical Insurance: *If your child is taken to the Cheshire Medical Center, they will bill you directly. When you receive the bill, please submit it to your insurance company and send a copy to Camp Spofford. Camp Spofford will cover any cost your insurance company will not cover provided that you submit all claims within 1 year of injury. If you do not have medical insurance, you must submit the bill directly to Camp Spofford within 1 year of injury to receive coverage.*

I understand and accept Camp Spofford's Emergency Medical Treatment Authorization.

Parent/Guardian signature _____ Date _____

PART 2 of 2

To Be Filled Out by Your Doctor

I have examined _____ (patient) on _____ (date)
(must be within two years prior to expected camp entrance date). On this basis, I have the following comments
regarding his/her participation:

Doctor's Name _____ Phone _____

Doctor's Signature _____ Date _____

Health History (check if it applies)

____ AIDS/ARC ____ Diabetes ____ Lice Other: _____
____ Asthma ____ Ear Infections ____ Rheumatic Fever _____
____ Athlete's Foot ____ Epilepsy ____ Tonsillitis _____
____ Convulsions ____ Frequent Sore Throats ____ Tuberculosis _____

Allergies (check if it applies)

____ Hay Fever ____ Insect Stings/Bites ____ Foods (specify) _____
____ Pollens ____ Plants (Poison Ivy, etc.) ____ Drugs (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 _____

Immunization History - list the date last booster received

Diphtheria _____ Tetanus _____ Polio _____
MMR _____ Tuberculin test given (most recent) _____ Positive/Negative
Hepatitis B (if born on/after 1-01-93)

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 _____