Connecticut Rivers Council, Boy Scouts of America **Resident Camp Medical Form**

NEW MEDICAL FORM PROCEDURES

- **This side of the form is to be completed every year to ensure all information is current and correct.**
- **The Physical Exam on page 2, may be resubmitted up to 36 months from the date of exam for those under age 40. Those adult leaders age 40 and over require an annual health exam.**

___Staff ___Adult Leader Troop Number_____
___Camper Dates Attending_____

Name:_____Sex: M/F_____DOB:_____Age:_____
(last) (first)

Address:_____Phone:_(___)_____Child lives with:_____
(street) (town) (zip code)

Parent/Guardian Name:_____Phone:_(___)_____(___)_____(___)_____
(home) (work) (cell)

Parent/Guardian Name:_____Phone:_(___)_____(___)_____(___)_____
(home) (work) (cell)

If unable to reach parent/guardian, please notify:_____Phone:_____

Insurance Carrier:_____Policy#_____Group#:_____

(or attach a copy of the front and back of insurance card) Primary Cardholder_____

Health History

To be completed by Parent/Guardian

- Do you take any prescription or over-the-counter medications? Y/N_____
  *If medications are needed at camp that are not included in the paragraph below, please attach an **Authorization for the Administration of Medication by Camp Personel** for each, signed by parent and MD. (available at www.ctrivers.org)*
- Do you have any allergies to food/medications or other? Y/N Please describe substance, type of reaction, and treatment.

_____

Note: If medications are required for treatment of allergic reaction, please include allergy treatment plan, signed by parent and MD. (sample available at www.ctrivers.org)

- Chronic/Recurring Illness: *(please check)* Asthma____ *(*Attach MD treatment plan if severe.)*
  *Diabetes____ *Epilepsy/Seizures____ *(*Require physician treatment plan)*
  Heart Condition____ High Blood Pressure____ Abdominal____ Mental Health____ Surgery____ Other____
  Please explain details of above._____
- **Date of last Tetanus Immunization: ____/____/____**

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 comment section, attaching an additional sheet if necessary.

This medical form is correct so far as I know, and the person named in Part 1 has permission to **participate in all camp activities** except as noted on the form by me or on the reverse by 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 medication.
I hereby request that the camp's Health Officer administer the **prescription and/or over-the-counter medication(s)** ordered by my child's doctor/dentist. 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 a 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 also give permission for my child to **participate in trips** sponsored by the camp and approved by the adult/unit leader in charge. Examples of these trips are whitewater merit badge, orienteering merit badge or trips for rock climbing or mountain biking.
The Connecticut Rivers Council may take **pictures and/or videos** for use as camp promotional material for the camp and/or programs and I realize that my child's likeness and/or mine may appear in this material.
I give my permission for the Camp Health Officer to administer over-the-counter medications as directed for conditions as directed by the Camp Physician. (The over-the-counter medications may include **WOUNDS**: Betadine, Hydrogen Peroxide, Bacitracin antibiotic ointment **POISON IVY**: Tecnu, Benadryl cream **CANKER SORES**: Benzocaine cream **PAIN**: Tylenol, Ibuprofen **DYSMENORRHEA**: Ibuprofen **ABDOMINAL DISCOMFORT**: Tums, Maalox **HEADACHE**: Tylenol, Ibuprofen **HYPOGLYCMIA**: Glucose gel, Glucagon **ALLERGIC REACTION**: Benadryl or generic, Epipen **ATHLETE'S FOOT**: Tinactin **INSECT STING/BITE**: Benadryl cream, Hydrocortisone cream, Caladryl or Calagel, Epipen **TICK BITES**: Alcohol or Hydrogen Peroxide **1st DEGREE BURNS**: Burn Jell, Aloe Spray **EMERGENCIES**: Oxygen, Generics may be substituted.

Signature:_____Date Signed:_____
(Adults over 18 sign here. Parent/Guardian signs for camper.)

Name (print):_____

Comment:

Name: Troop: Campsite:

Camp Health Exam for Campers, Staff and Adults

Physical exams are valid for 3 years from date of last exam for those under the age of 40, and for 1 year for those 40 and over. A current school medical form may be substituted for this section.

TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER:

Name_____ Date of Birth _____/_____/_____ **Date of Exam _____/_____/_____**

_____ May participate in all camp activities
_____ May participate except for: _____

_____

Medical information pertinent to routine care and emergencies: _____

Blood pressure: _____/_____ Pulse: _____ Height:: _____ Weight: _____

Is this individual taking prescription or over-the-counter medications? ☐ Yes ☐ No _____
If yes, please attach Authorization for Administration of Medication by Camp Personnel if not listed under Standing Orders, page 1.

Does this individual have allergies? ☐ Yes ☐ No Explain:_____
Please attach allergy treatment plan for severe allergies requiring medications

Does the individual require a special diet? ☐ Yes ☐ No Explain: _____

Does the individual have special needs? ☐ Yes ☐ No Explain: _____

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	Had Disease		Yes	No	Had Disease
Measles				Hepatitis B			
Mumps				Diphtheria			
Rubella				Pertussis			
Chickenpox				Polio			
Tetanus *Date_____							

Comments _____

_____

Print name of medical care provider: _____

Medical care provider's address: _____
street *city* *state* *zip*

Doctor's Stamp

_____
Signature of Physician, APRN or PA

_____
Date signed

(_____) _____
Telephone Number