CSU Summer Camp

Contact Information and Release Form

Name: _____ Date of Birth: _____

Home Address: _____

_____

Phone #: _____ Gender: _____ Age: _____

Email: _____

Parent/Guardian Contact Information (include location during camp session)

Parent/Guardian 1: Name: _____

Address: _____

Home Phone#:_____ Cell #:_____

Location/phone# during camp: _____

Parent/Guardian 2: Name: _____

Address: _____

Home Phone#:_____ Cell #:_____

Location/phone# during camp: _____

Emergency Contacts

Name: _____ Relationship: _____

Phone #: _____

Name: _____ Relationship: _____

Phone #: _____

Family Health Insurance Company Name, Address, and Policy #:_____

_____

Family Physician Name and Phone #: _____

Family Dentist Name and Phone #: _____

CONSENT FOR MEDICAL TREATMENT FOR A MINOR (one form per child)

As parent or legal guardian of I hereby give my consent for emergency medical care prescribed by a duly licensed Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions are necessary to preserve life, limb, or the well being of my dependent. “I understand that the directors and coaches of Cambridge Sports Union or anyone associated with the sites we run our camp at, its trustee, agents and officers, will not assume responsibility for accidents and medical or dental expenses incurred as a result of participation in this program. The applicant is covered by our family insurance, is in good health, and able to participate in the physical activity of a vigorous program. I hereby authorize the camp directors to act for me accordingly to their best judgment in any emergency requiring medical attention in the event that I and my emergency contacts cannot be reached. I will hold harmless Cambridge Sports Union, and any other site used by Cambridge Sports Union, it’s trustees, agents and officers of any and all liability actions, causes of action, claims and demands of every kind and nature whatsoever which may arise in connection either with or resulting from participation in any of its activities.”

Parent or Guardian Signature: _____Date: _____

CSU Summer Camp

Medical Form / Certificate of Immunization

You may substitute the standard form provided by the physician's office

Name: _____ Date of Birth: _____

HEALTH HISTORY: (Circle any that apply)

Heart Problems	Hay Fever	Earaches	German Measles	Asthma
Sinus Problems	Whooping Cough	Measles	Chickenpox	
Bee Sting Allergy	Diabetes	Mumps	**Drug Allergy**	Seizures
Ivy, Oak Allergies	Glasses	Contacts	**Food Allergy (specify)**	

Detail any of the above: _____

_____

_____

_____

_____

_____

Medication being taken (name and explain): _____

_____

_____

Operations, injuries, special restrictions (give dates): _____

_____

_____

HEALTH EXAMINATION:

Date of last physical examination by licensed physician: _____

(*must be within 24 months preceding your child's participation at CSU's summer camp program)*

RECORD OF IMMUNIZATIONS: List month and year

DTaP/DTP/DT (4 doses)	_____	_____	_____	_____
Polio (3 doses)		_____	_____	_____
Hepatitis B (3 doses)		_____	_____	_____
M.M.R. (2 doses)			_____	_____
Td booster (1 dose while in Grades 7-12)				_____

I certify that the above medical information is complete and accurate, and the above named program participant may fully participate in the camp program.

Physician Signature: _____ Date: _____

Print Name: _____

Address: _____Phone: _____

Parent Signature: _____ Date: _____

(*Parent signature certifies that no significant health problems have occurred since date of exam*.)

AUTHORIZATION TO ADMINISTER MEDICATION TO A CAMPER
(To be completed by parent/guardian)

Name of Camper: _____ Age: _____

Parent/Guardian Name: _____

Home Phone#: _____ Cell#: _____

Emergency Phone#: _____

Food/Drug Allergies: _____

Name of Licensed Prescriber: _____
Phone #: _____Emergency Phone #: _____

Diagnosis (at parents discretion): _____

Name of Medication: _____

Dose to be given at camp: _____ Route of Administration: _____

Frequency: _____ Date Ordered: _____ Duration of Order: _____

Quantity Received: _____ Expiration date of Medications Received: _____

Special Storage Requirements: _____

Specific Directions (e.g., on empty stomach/with water): _____

Specific Precautions: _____

Possible Side Effects/Adverse Reactions: _____

Other medications (at parents' discretion): _____

AUTHORIZATION:
I hereby authorize _____ (NAME OF CAMP) to administer, to my child, the medication(s) listed above, in accordance with 105 CMR 430.160.

105 CMR 430.160(A): *Medication prescribed for campers shall be kept in original containers bearing the pharmacy label, which shows the date of filling, the pharmacy name and address, the filling pharmacist's initials, the serial number of the prescription, the name of the patient, the name of the prescribing practitioner, the name of the prescribed medication, directions for use and cautionary statements, if any, contained in such prescription or required by law, and if tablets or capsules, the number in the container. All over the counter medications for campers shall be kept in the original containers containing the original label, which shall include the directions for use*.

105 CMR 430.160(C): *Medication shall only be administered by the health supervisor* or by a licensed health care professional authorized to administer prescription medications. The health care consultant shall acknowledge in writing the list of medications administered at the camp. If the health supervisor is not a licensed health care professional authorized to administer prescription medications, the administration of medications shall be under the professional oversight of the health care consultant. Medication prescribed for campers brought from home shall only be administered if it is from the original container, and there is written permission from the parent/guardian*.

105 CMR 430.160(D): *When no longer needed, medications shall be returned to a parent of guardian whenever]possible. If the medication cannot be returned, it shall be destroyed*.

*Health Supervisor – A person who is at least 18 years of age, specially trained and certified in at least current American Red Cross First Aid (or its equivalent) and CPR, has been trained in the administration of medications and is under the professional oversight of a licensed health care professional authorized to administer prescription medications.

Parent/Guardian Signature: _____ Date: _____