eCamps Inc. Summer Camp Health Record

Every camper must have this health record filled out and bring it with them to camp check-in. Camps held in the following states require this form to be completed and signed by a physician before your child can participate at summer camp, (CT, MA, NY).

PLEASE DO NOT MAIL AHEAD.

Camp Attending:___________________________________

Name:____
Last First Middle Initial

DOB:______________ Age:____________ Sex:_______

Parent/Guardian:________________________________

Address:_______________________________________

Phone (Home):__________________________________

Phone (Work):___________________________________

Phone (Cell):____________________________________

*Emergency Contact:*______________________________

*Phone (Home):*__________________________________

*Phone (Cell):*___________________________________

Health History

____May Participate in all camp activities

____May participate except for_____________________

____

Does this individual have allergies? ☐ YES ☐ NO

Explain:______________________________________

____

Is this individual on a special diet? ☐ YES ☐ NO

Explain:______________________________________

____

Does the individual have special needs? ☐ YES ☐ NO

Explain:______________________________________

____

I have examined the above camper with in the past two years.

Date Examined_________________

Physician's Signature______________________________

Physician's Name_________________________________

Today's Date_____________________________________

Address____

Phone ____

PLEASE NOTE: DOCTOR SIGNATURE IS ONLY REQUIRED FOR CAMPS IN CT, MA & NY

Immunization History (Please List Dates)

Copy of Immunization Record Preferable with copy of physical within the last 18 months

DPT _______ Booster________

Meningococcal vaccine (required for grade 7-12)

____

DT________

Polio OPV (Sabin)_______ Booster__________

Measles/Mumps/Rubella (MMR) #1_________

#2_________ Hepatitis B #1_______ #2________

#3_______ Chickenpox__________

Tetanus_________

Turberculin_________

Pneumococcal Conjugate___________

Haemophilus Influenza b (HIB)__________

COVID-19 #1______ #2_______ Booster ______

Insurance Information

*Health Insurance Provider:*________________________

Policy/ID Number_______________________________

Policy Holder's Name & DOB______________________

*Insurance Provider Contact: Phone*_________________

Mailing Address__________________________________

Please include a photocopy of your Health Insurance card for our records.

Parent's Authorization

This health history is correct so far as I know, and the person herein described has permission to participate in all activities except as noted.

I give my child permission to be treated by emergency response personnel. I understand that every attempt will be made to contact me, or the emergency contact, before taking this action. I hereby waive and release eCamps Inc, staff, camp management and sponsors from any liability for any injury or illness incurred while at camp. I UNDERSTAND THAT THERE IS A RISK OF INJURY TO MY CHILD AS A RESULT OF CAMP ACTIVITIES, AND KNOWINGLY AND VOLUNTARILY ASSUME ALL RISK OF SUCH INJURY. I will be financially responsible for any medical attention needed during camp.

Parent Signature_____________________Date__________

NOTEMedication will be checked and kept by the staff. All prescription medications must be in their original case/box with the legible prescription label; including inhalers. The "prescriber's authorization form" must accompany all medication and requires the physician's signature in CT, MA & NY.

Individual Plan of Care for Campers - Required for CT

This form is ***REQUIRED*** for any camper who requires any special health care needs or special attention that the staff and first aider needs to be made aware of and instructions on how to treat. ***If your camper has any of the below needs, this form must be signed for camps in CT. If this form is not completed, your camper will not be allowed to attend camp. YOU MUST get this form signed by camp director and athletic trainer at check-in to participate in camp***

Child's Name:__________________________ Date of Birth_____/______/_______

My Child Has Any of the Following Medical Needs, Allergies, Dietary Restrictions, Etc:

Has an Inhaler : Y / N - If YES, the inhaler MUST be stored in the original packaging and have proper labeling containing camper name and information, along with admin of medication form

Has an Epi-pen: Y / N - If YES, the epi-pen MUST be stored in the original packaging and have proper labeling containing camper name and information, along with admin of medication form

Has Allergies that Require Prescription Medication: Y / N - If YES, the medication MUST be stored in the original packaging and have proper labeling containing camper name and information, along with admin of medication form

Needs Any Other Prescription Medication while at Camp: Y / N - If YES, the inhaler MUST be stored in the original packaging and have proper labeling containing camper name and information, along with admin of medication form

Other Medical/behavioral needs Staff Needs to be aware of, Please Elaborate:

Plan for appropriate care of the child in a medical emergency. An individual Plan of Care is necessary when a child has a special health care need or disability and it is necessary that special care be taken or provided while the child is at the youth camp. Please include all relevant information: (e.g. precautions to be taken to prevent a medical or other emergency) .

Signature(s) of the Parent(s): Date Signed:

___________________________________ ____/_____/_____

___________________________________ ____/_____/_____

Individual Care Plans requires a child's health record to include information regarding disabilities or special health care needs such as allergies, special dietary needs, dental problems, hearing or visual impairments, chronic illness, developmental variations or history of contagious disease, and an individual plan of care for the child with special health care needs or disabilities. Such a plan of care shall include appropriate care of the camper in the event of a medical or other emergency and shall be signed by the parent(s) and staff responsible for the care of the camper.

Signature of the staff responsible for camper ____(first aider signature)

Signature of the staff responsible for camper ____(staff member signature)

Please use the reverse side of this form for signature(s) of all staff responsible for the care of this child if needed

Authorization of Self-Administration Medication Form

This form allows both the parent/guardian and the prescriber to ensure the camper is capable of self-administering the medication safely while at camp***. If your camp requires any medication while at camp or ICE, you MUST complete this form in totality and present to first aider at check-in with medication.*** All medication MUST be brought to camp in the original container and have proper pharmacy labelling. If these conditions are not met and paperwork completed, your camper will not be allowed at camp. You MUST also complete an Individual Care Plan available on our website.

Camper Information:

- Camper's Full Name: ____________________________
- Date of Birth ___________________________________
-Camper Address: ________________________________
- Parent/Guardian Name: _______________________________
- Parent/Guardian Phone Number: _______________________
- Parent/Guardian Email: ________________________________

Medication Information:

- Name of Medication: ____
- Dosage: ____
- Time(s) of Administration: ___________________________________
- Condition being treated: ______________________________________
-Specific Instructions for Medication Administration: ____
- Potential Side Effects____ None Expected ☐
-Plan to Address Potential Side Effects: ____

Parent/Guardian Authorization for Self-Administration:

☐ I, the undersigned parent/guardian, hereby authorize my child, named above, to self-administer the medication listed above while attending the summer camp program. I understand that my child has been instructed by a healthcare provider on how to properly administer this medication. I am confident in my child's ability to safely and responsibly manage this medication while at camp.

☐ I agree to provide the camp with an adequate supply of the medication, properly labeled, in accordance with camp policy. I also understand that the camp staff may provide assistance if necessary and that the camp will monitor my child's adherence to medication administration as best as possible.

Parent/Guardian Consent:

- Parent/Guardian Signature: _____________________________________
- Date: ____
- Relationship to child: ____

Prescriber's Authorization:

☐ I, the undersigned prescribing healthcare provider, authorize the child named above to self-administer the medication as described. I confirm that this child has been educated on the proper use of the medication, including potential side effects, and is capable of administering it independently while at camp. I understand that the camp staff will make reasonable accommodations for the camper's health and safety during the camp session.

- Prescriber's Full Name: ____
- Prescriber's Title: ____
- Prescriber's Contact Information: ________________________________
- Prescriber's Signature: ____
- Date: ____

For Camp Use Only:

- Medication Received: [ ] Yes [ ] No
- Camp Staff Notified: [ ] Yes [ ] No
- Medication Stored Appropriately: [ ] Yes [ ] No

Important Notes:

- **All medications must be brought to camp in their original, pharmacy-labeled container**.
- **Any changes in medication, dosage, or administration must be communicated to the camp immediately.**

Camp First Aider Signature: ____

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 or Administering Medication** (First Aider or Staff Member Resp)
				Yes ☐ **No** ☐	
				Yes ☐ **No** ☐	
				Yes ☐ **No** ☐	
				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.

☐ **Authorization form is complete**
☐ **Medication is appropriately labeled**
☐ **Medication is in original container**
☐ **Date on label is current**
☐ **The Individual Care Plan Form is complete**

Person Accepting Medication (print name)______________________________ **Date** _____/_____/_____