

COERVER COACHING CONNECTICUT-HEALTH FORM

Please complete the health form and return it before you start camp. You can have your physician sign this form and attach a school health form that is less than 36 months old. You can bring the form with you to camp registration, but your child cannot start camp without the completed form.

| | | | |
|--------------------|------------------|-------------------------------|--------------------------------------|
| Campers First Name | | Last Name | |
| Address | City | State/Zip | |
| Age | Date of Birth | <input type="checkbox"/> Male | <input type="checkbox"/> Female |
| Camp Location | Date/s Attending | <input type="checkbox"/> Day | <input type="checkbox"/> Residential |

| | |
|---------------|------------|
| Parents Names | |
| Home Phone | Work Phone |

Immunization Record

| | | | | | |
|-------------|-----------------|-----------------|-----------------|---------|---------|
| DPT | 1 st | 2 nd | 3 rd | Booster | Booster |
| ORAL POLIO | 1 st | 2 nd | 3 rd | Booster | Booster |
| MEASLES | Date | Rubella | Date | Mumps | Date |
| HEPATITIS B | 1st | 2nd | 3rd | | |
| H.I.B | 1 st | 2 nd | 3rd | | |
| MMR No 2 | Date | | | | |

Allergies

| | |
|----------------------------|---------------|
| Any allergy problems? | If yes, what? |
| Any allergies to any drugs | If yes, what? |

General Health Information

| | | | |
|---|------------------------------|-----------------------------|---------------|
| Has the child been exposed to any communicable disease in the 3 weeks prior to camp? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, what? |
| Is the child currently on Medication? Yes No If yes, what? | | | |
| Are you sending the medication to camp with the child? Yes No | | | |
| If camp personnel are requested to administer medications be sure to complete the medication authorization form on the back of this form. State law requires a physicians written order and parent or guardians written authorization. | | | |
| Any swimming restrictions? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, what? |
| Any other activity restrictions? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, what? |
| Any other significant medical history? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, what? |

Any other parent's comments or suggestions concerning the camper's health.

Doctors Authorization

I have reviewed the health history of the above individual. It is my opinion that this individual is physically able to engage in any and all camp activities, except as noted above.

| | | |
|------------------|----|------------|
| Signed: | MD | Date: |
| Doctors address: | | Telephone: |

Parents Authorization and Medical Release

To the best of my knowledge, this health history is correct. The individual described has my full permission to engage in all camp activities except as noted above. I hereby give my full permission to the physician or emergency medical personnel selected by the camp director or camp medical officer to order x-rays, tests and treatment for my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician or emergency medical personnel selected by the camp director or camp medical officer to hospitalize and secure proper treatment, and to order injection and/or anesthesia and/or surgery for my child.

I agree that my tuition payment or deposit is nonrefundable, but is transferable to any other Coerver Connecticut program. I also agree that any photographs, video or any other record of this event may be used for publicity, advertising or any other legitimate purpose.

| | |
|------------|-------|
| Signature: | Date: |
|------------|-------|

Mail this health form to: Coerver Coaching, 58 Hawks Hill Rd, New Canaan, CT 06840 (203) 966-8081

**AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATIONS
BY COERVER CAMP PERSONELL**

In order for Coerver camp personnel to administer medications, Connecticut state law and regulations require a physician's or dentists written order and parent or guardian's authorization for a nurse, first aider, the director, alternate director or camp counselor to administer medications. Medications must be in pharmacy prepared containers and labeled with the name of the child, name of the drug, strength, dosage, frequency, physician's or dentists name and date of the original prescription. Over the counter medication must be in the original container and labeled with the child's name.

PHYSICIAN OR DENTIST'S ORDER:

Date ___/___/___

Name of Child: _____ Date of Birth ___/___/___
Street Address: _____ City/Town: _____ State: _____ Zip: _____
Condition for which drug is being administered during camp hours _____

DRUG: Name of drug, dose and Method of Administration: _____

Times of Administration: ____, ____, ____ Medication shall be administered from: (date) ___/___/___ to ___/___/___
Relevant side effects to be observed, if any: _____

If there are side effects, plan for management: _____

Is this a controlled drug? _____
Allergies to food or drugs? IF YES, List _____

PHYSICIAN'S / DENTISTS NAME: _____ Phone #: () _____
Street Address: _____ City/Town: _____ State: _____ Zip: _____
Physician or Dentist's Signature: _____

AUTHORIZATION BY PARENT OR GUARDIAN FOR THE ADMINISTRATION OF THE ABOVE MEDICATION:

Date: ___/___/___

To nurse, first aider, director, alternate director, or youth camp counselor:
I hereby request that the above medication, ordered by the physician/dentist for my child, _____
be administered by the nurse, first aider, director, alternate director or youth camp counselor.

I understand that I must supply the camp with the prescribed medication in the original container dispensed and properly labeled by a physician or pharmacist. Over the counter medication shall be in the original container labeled by the parent with the child's name.

I understand that this medication will be destroyed if it is not picked up within one week following termination of the order.

Name of Parent or Guardian: _____ Signature: _____

Relationship to child: _____

Street Address: _____ City/Town: _____ State: _____ Zip: _____

Phone: () _____