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 From Last 18 Months Preferable.

DPT _____ Booster_____

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

I warrant and represent to eCamps Inc - Revolution Field Hockey, that I am the parent and/or guardian of the above-named participant and that I am authorized to execute this Consent and Release on behalf of my minor child. 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, Revolution Field Hockey, staff, camp management and sponsors from any liability and for all claims resulting from any injuries or illness sustained by my child while at camp. I UNDERSTAND THAT THERE IS A RISK OF INJURY TO MY CHILD AS A RESULT OF THE SPORT AND CAMP ACTIVITIES. I hereby give permission to the coaches, training staff, and other medical professionals to provide medical care as deemed necessary to my child in case of any injury or illness, and I agree that I will be financially responsible for the cost of the same. I also acknowledge receipt of concussion information that is provided via link in the confirmation packet.

Parent Signature_____Date_____

*****NOTE***All medication will be checked and kept by the trainer. All prescription medications must be in their original casebox with the legible prescription label; including inhalers. The "prescribers authorization form" must accompany all medication and requires the physician's signature in CT, MA, & NY. The Administration of Medication and the Individual Care of Camper Plan Forms must accompany all medication for camps in CT. This form is available for download on FHCamps.com.**

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** _____/_____/_____