THE FOLLOWING SECTION MUST BE COMPLETED AND SIGNED BY PARENT/GUARDIAN

DUNNABECK

(845) 373-8111

Dear 2020 Camp Dunnabeck Parents,

Health and safety are our number one priorities at camp. The Health Center maintains 24/7 nursing staff as well as CPR/AED/ First Aid trained support staff. To ensure your camper's enjoyment and success this summer, it is important that you inform us of any allergy, health, diet, personal habits and/or behavioral issue as soon as possible. This includes any professional assistance you have sought for the treatment of such problems. All disclosures are kept in professional confidence. Such information is crucial to enable our staff to assign, train, and supervise our counselors to best serve the needs of your camper.

All campers are required to have a valid physical exam and proof of immunization. In order for your camper to be admitted to camp, you must provide this written documentation.

For acute medical needs such as an ear infection or strep throat, we have an offsite physician. For emergency medical needs campers are transported to Sharon Hospital. In both instances, campers are accompanied by one of our adult staff. All visits to the physician, urgent care and/or emergency department will be billed through your family or camper's individual insurance policy. With the exception of an emergency, parents will be notified prior to any visits to the pediatrician or urgent care. Parents are ultimately responsible for payment of medical bills related to illness and injuries.

This summer we **require** all prescription and/or over the counter medications be provided to our campers by Kent Apothecary in Kent, CT. Kent Apothecary will package each child's medications in a customized, portable pack, which will be delivered to Camp Dunnabeck before he or she arrives. This guarantees accurate, timely dosing and dispensing of your camper's medication while they are away from home this summer. Only medication that is medically necessary will be adminstered. Regimented supplements/herbals will not be administered as they are not in accordance with CTS law as being medically necessary.

State law requires that all medications, including over the counter, can only be dispensed by a nurse to a camper with a written order from a physician (MD/DO only), nurse practitioner, physician assistant (PA). To register with Kent Apothecary please contact them directly at:

Kent Apothecary
38 North Main Street
Kent, CT 06757

Ph.: (860) 927-3725 Fax: (860) 927-3895

We're looking forward to a safe and enjoyable camp season. If you have any questions or concerns, please call us at (845) 373-8111, or you may email the Health Director, Jennifer Amato, at jamato@kildonan.org

Sincerely,

Camp Health Office

CAMP DUNNABECK HEALTH FORM

Camper Name: _____ **DOB:** _____ **Grade:** _____

Parent 1:	Parent 2:
Name:	Name:
Address:	Address:
City: State: Zip:	City: State: Zip:
Home:	Home:
Cell:	Cell:

INSURANCE INFORMATION

Every camper is required to have some form of comprehensive medical insurance. Please furnish us with the following information so that we may provide your camper with the care that he/she deserves, in an expeditious manner. **Please enclose a photocopy (front and back) of your campers's insurance card and pharmacy card.**

Subscriber Information (required)	**Insurance Information (required)**
Name:	Insurance Company:
DOB: SS#:	Group #:
Address:	ID#: Person Code:
	Insurance Address:
Phone:	
	Phone:

RELEASE OF LIABILITY FOR MEDICATIONS DISBURSED FOR WEEKENDS/EXCURSIONS

By signing below I acknowledge that if my camper leaves campus overnight or for the weekend (e.g., trip home, visiting a friend's house), I hereby authorize the Camp Dunnabeck Health Center to provide necessary prescription medication to my camper. I understand that my camper will either be in my care or the care of another adult, and that adult (or my camper) will be responsible for administering any prescription medication that is required. Please note that this is not only for regularly prescribed medication; it also applies to antibiotics or other medication.

** I understand the risks involved when personal health information is transmitted via unencrypted email, and hereby give Camp Dunnabeck permission to use unsecured email and/or mobile phone text messaging to communicate with me regarding the above named camper's personal health information.

PERMISSION FOR MEDICAL/SURGICAL TREATMENT: *This section must be signed in order for your camper to attend camp.*

I authorize the administration (the "Administration") of Camp Dunnabeck (the "Camp") to arrange for medical care and treatment, including medications, immunizations, drug testing and diagnostic tests for injuries and illnesses that my camper may suffer while attending the Camp (whether or not such injuries or illnesses occur on campus). I also agree to notify Camp health personnel of any medical conditions arising when my student is not at School. Also, in the event of an emergency in which a delay in treatment may result in an increased risk to the life or health of my student, I authorize Administration to arrange for physician, hospital and other required medical care which may be deemed necessary by the treating health care provider to minimize any such risk to my camper, including, but not limited to, diagnostic tests, hospitalization and/or surgery. I understand that I am responsible for all medical and dental expenses associated with the treatment of my camper. I consent to the provision of such medical care.

_____ _____

Signature of Parent or Guardian Date

Return this form to the Camp Office

CAMP DUNNABECK HEALTH FORM

Examination Date: _____

Camper Name: _____ DOB: _____

Hearing Screening: Right Ear: Left Ear: **Vision Screening:** Right Eye: Left Eye: Both Eyes: Corrective Lenses: ☐ Yes ☐ No	Gender: ☐ M ☐ F HT: WT: BP: Scoliosis: ☐ Neg ☐ + Curve Tanner Stage 1 2 3 4 5 PPD: Date: ☐ Low Risk for TB (No PPD Date)	**Allergies:** **Prior Medical History:**

☐ The camper has the following health issues that may impact the educational experience:

_____

_____

Certificate of Immunizations

☐ Immunization record attached

DTP/DTaP					
Polio					
Pneumococcal					
MMR					
Meningococcal					
HIB					
Hepatitis B					
Td/Tdap					
Varicella					
Hep A					
HPV					
Rotavirus					

☐ **All Findings Within Normal Limits**

☐ **May participate in all normal activities including competitive sports**

☐ Restrictions _____

Physician's Signature:_____ **Date:** _____

Physician's Name: _____ Phone _____

Address: _____ License # _____

_____

Return this form to the Camp Office

Camper Name: _____ **Date:** _____

Prior Medical/Surgical History:

***PROVIDER REQUEST FOR MEDICATION REQUIRED DURING SCHOOL/SCHOOL SPONSORED EVENTS**

This form is valid for one (1) year and **MUST** be completed and signed by the camper's physician. State law requires that all medications, including over the counter, can only be dispensed by a nurse to a camper with a written order from a physician (MD/DO only), nurse practitioner, physician assistant (PA). All medications **MUST** be presented in their original containers.

Please complete the chart below with the patient's current regimen for both scheduled (prescribed and over the counter) and as needed (PRN) medications.

MEDICATION ORDER FORM:

Medication	Dosage	Route	Time	Comments
** Ibuprofen*	*500mg*	*PO*	*qam*	*with food*

*** Please give indication regarding missed dosage protocol in comments*

ASTHMA & INHALERS: Independent Carry & Use Option - CTS law requires physician attestation that the camper has demonstrated that they can effectively self-administer inhaled respiratory rescue medication.

☐ **I have determined that this child is subject to sudden asthmatic attacks severe enough to require the use of the prescribed inhaler, as listed above, in school, and is allowed to carry the inhaler on their person.**

Physician's Signature:_____ **Date:** _____

Physician's Name: _____ Phone _____

Address: _____ License # _____

_____

Parent Signature: _____ Date: _____

Return this form to the Camp Office

CAMP DUNNABECK HEALTH FORM

Camper Name: _____ **DOB:** _____ **Grade:** _____

Parents, please fill out the following health history questionnaire completely and accurately.

ALLERGIES:
Does your child have any drug allergies? _____ If you answered yes, please specify to which drugs your child is allergic and the reaction caused.

Does your child have any other allergies? (e.g., environmental, seasonal, food, insect bites, other...) Please specify and indicate type of reaction.

MEDICAL/SURGICAL HISTORY:
Please indicate any recent or chronic medical conditions that your child has received medical treatment for: (e.g., Skin conditions, ulcers, asthma, diabetes, epilepsy, tonsilitis, mononucleosis, gallstones, appendicitis, chicken pox, fractures, neurological conditions, kidney disease, other...)

Please indicate any mental health diagnoses for which your child has been treated for (e.g., ADHD, depression, anxiety disorder, bipolar, eating disorder, etc...) and treatment (e.g., counseling, medication, hospitalization, etc.)

Please indicate whether your child has any history of substance use (y/n): _____ alcohol _____cigarettes/tobacco _____ Marijuana _____ prescription drug abuse _____ other drugs _____ other substances
Please indicate any treatments, evaluations or recommendations made for history of substance use _____

Does your child follow a special diet or have any dietary restrictions? If yes, please specify.

PHYSICIAN INFORMATION:
Please list all physicians, specialists, psychologists, and/or psychiatrists your child sees on a regular basis and/or prescribe medicine for your child. Please include address and telephone number.

1. **Primary Physician**:

2.

3.

Return this form to the Camp Office

CAMP DUNNABECK HEALTH FORM

Sunscreen and Bug Spray Permission Form

Dear Parents,

The nursing department would like to inform you that our camp staff and counselors will be providing sunscreen and bug repellent to your camper. The staff and counselors will provide a generic sunscreen and bug repellent during the course of the camp day as needed. Below are the details on each of the products:

Sunscreen: is an aerosol generic brand with an SPF rating of 50 that is also water-resistant. The Active Ingredients are: Avobenzone Homosalate, Octisalate and Oxbenzone.

Bug Spray: Off Insect Repellent. Active Ingredients are DEET 15%

If you ***do not*** wish to have sunscreen and/or bug repellent provided to your child for any reason, please email the nurse at jamato@kildonan.org.

If you have a specific brand that you only want to have provided to your child please email that information and send in the products. They will be labeled with your child's name and given to the camp staff and counselors.

Thank your for your cooperation. If you have any questions please feel free to call the nurse at 845-373-8111.

Camp Health Office
jamato@kildonan.org

Please circle ONE:

I (**GIVE** / **DO NOT GIVE**) the nursing staff and camp counselors permissions to provide:

____ Sunscreen ____ Bug Spray

to my camper, _____ as needed during the 2020 Camp Dunnabeck program.

_____ _____

Parent Signature Date

Return this form to the Camp Office

CAMP DUNNABECK HEALTH FORM

Child's Name: _____

Standard Over the Counter / PRN Medications
The following medications are available in the Infirmary and will be administered at the discretion of a RN/LPN if approval is indicated by the student's healthcare provider/camp physician.

Drug Name	Route	Dosage/ Schedule	Indications	Health Care Provider Order	Comments
Tylenol (or generic)	**PO** (chewable, elixir, or tabs) **PR** (suppository)	Per label Instructions	Pain or fever	Yes No	
Ibuprofen	**PO** (chewable, elixir, or tabs)	Per label Instructions	Pain or fever	Yes No	
Robitussin (or generic)	**PO** (syrup)	Per label Instructions	Cough	Yes No	
Imodium (or generic)	**PO** (liquid or chewable tabs)	Per label Instructions	Upset stomach, diarrhea	Yes No	
Zyrtec/Claritin (or generic)	**PO** (Chewable tabs, suspension, tabs)	Per label Instructions	Seasonal allergy symptoms	Yes No	
Benadryl (or gereric)	**PO/Topical** (Elixir, chewable tabs, pills)	Per label Instructions	Allergic reactions (hives, insect bite)	Yes No	
Antibiotic Ointment	**Topical**	Per label Instructions	Superficial cuts/ abrasions	Yes No	
Hydrocortisone Cream	**Topical**	Per label Instructions	Allergic reactions (contact dermatitis, insect bites)	Yes No	
Calamine Lotion (or generic)	**Topical**	Per label Instructions	Allergic reactions (hives, insect bite)	Yes No	

Physician's Signature: _____ Date: _____

Return this form to the Camp Office