

CAMP DUNNABECK AT THE KILDONAN SCHOOL

HEALTH FORMS

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.

We recommend all prescription and/or over the counter medications be provided to our campers by Kent Pharmacy. Kent Pharmacy 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 administered. Regimented supplements/herbals will not be administered as they are not in accordance with CT 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 Pharmacy please contact them directly at:
Kent Station Pharmacy

Phone: (860) 927-3725

Please direct questions about Camp Dunnabeck's Health Services to our camp nurse:

Jennifer Amato
Camp Dunnabeck Health Services
(845) 373-2015 -Phone
jamato@kildonan.org



CAMP DUNNABECK - HEALTH SERVICES

Please read and complete all forms carefully and **paying close attention to the following specific questions:**

1. **Mandatory Permission for Treatment Form**: This permission form is required by all emergency care facilities before treatment will be given and is mandatory for enrollment at Camp Dunnabeck. Once you have filled in the top portion, please be sure to sign at the bottom.

1. a. **Personal Information**: Please note full address and all telephone numbers where parent/guardian may be reached in the event of an emergency.

1. b. **Insurance Information**: Please provide the student's health insurance information on the Permission to Treat Form. We require that all students (foreign and domestic) carry health insurance. If you have insurance cards, please make copies and attach to the form. If you are unable to make copies of your cards at home, please bring the cards with you to registration and we will make them for you.

*** Please remember to send us updates and/or changes of insurance/billing information during the summer.*

2. **Physical examination and screening**: The doctor **must** sign and fill out this page for your child to be allowed to participate in team sports activities per CT state law. This exam must be done yearly and prior to registration.

2. a. **Immunizations**: Connecticut enforces laws which refuse enrollment of any child who fails to comply with the immunization requirements of the state of Connecticut. Please be sure that all of your child's immunizations have been recorded and are up to date according to CT state guidelines, or that blood tests have been performed to prove immunity. Note: meningococcal vaccine is required for school entry in CT State. **If we do not have your child's complete immunization record or signed exemption forms in hand by registration your child will not be considered registered and will return home with you until we have the records.**

3. **Health History**: **This form is to be completed by all parents.** When portions of your child's health history are left off these records it is difficult for Camp Dunnabeck Health Services and area health care providers to provide the best possible care for your child. If there is any relevant health/mental health history that our school physician should know please include it on the form.

4. **Authorization for Administration of Medication Form by School , Childcare, or Youth Camp Personnel Please note: A separate form must be filled out for each medication***

Please direct questions about Camp Dunnabeck's Health Services to our camp nurse:

Jennifer Amato
Camp Dunnabeck Health Services
(845) 373-2015 -Phone
jamato@kildonan.org



CAMP DUNNABECK - PERMISSION TO TREAT

Student Name: _____ DOB: _____ Grade: _____

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

INSURANCE INFORMATION

Every student is required to have some form of comprehensive medical insurance. Please furnish us with the following information so that we may provide your student with the care that he/she deserves, in an expeditious manner. **Please enclose a photocopy (front and back) of your student'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 student 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 student. I understand that my student will either be in my care or the care of another adult, and that adult (or my student) 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.

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

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 student 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 child is not at Camp. 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 child, 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 student. I consent to the provision of such medical care.

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 child's personal health information.

In accordance with HIPPA (Health Insurance Portability and Accountability Act of 1996) laws, I hereby authorize Camp Dunnabeck and its affiliate entities to OBTAIN / RELEASE the aboved named individual's health information.

Parent/Guardian Signature: _____ Date: _____

Print Name of Parent/Gaurdian: _____

Return this form to: Camp
Dunnabeck Health Services



CAMP DUNNABECK - HEALTH HISTORY FORM

Camper Name: _____ DOB: _____ Entering 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, tonsillitis, 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. _____

Return this form to: Camp
Dunnabeck Health Services



Camper Name: _____

Date: _____

Prior Medical/Surgical History:

***PROVIDER REQUEST FOR MEDICATION REQUIRED DURING CAMP/CAMP 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 or 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
Example: * Ibuprofen	500mg	PO	9:00 a.m.	with food

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

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

ASTHMA & INHALERS: 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.

EPI PEN: I have determined that this child is subject to an allergic reaction severe enough to require the use of the prescribed Epi Pen, as listed above, in school, and is allowed to carry the Epi Pen on their person.

Physician’s Signature: _____

Date: _____

Physician’s Name: _____

Phone _____

Address: _____

License # _____

Parent/Guardian Signature: _____

Date: _____



CAMP DUNNABECK - OTC/ PRN MEDICATIONS

Camper Name: _____

Standard Over the Counter / PRN Medications

The following medications are available in the Camp Dunnabeck Health Center and will be administered at the discretion of an RN/LPN if approval is indicated by the camper's healthcare provider/camp physician.

Drug Name	Route	Dosage/ Schedule	Indications	Health care provider order	Comments
Tylenol (or generic)	PO (Chewable, elixir, or tabs)	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	
Tums (or generic)	PO (Liquid or chewable tabs)	Per label Instructions	Upset stomach, diarrhea	Yes No	
Zyrtec/Claritin (or generic)	PO (Chewable or suspension)	Per label Instructions	Seasonal allergy symptoms	Yes No	
Benadryl (or generic)	PO/Topical (Chewable, elixir, or tabs)	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: Camp
Dunnabeck Health Services



Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel

In Connecticut schools, licensed Child Care Centers and Group Care Homes, licensed Family Care Homes, and licensed Youth Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child shall provide the program with appropriate written authorization(s) and the medication before any medications are administered. Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and date of the prescription.

Authorized Prescriber's Order (Physician, Dentist, Optometrist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist):

Name of Child/Student _____ Date of Birth ___/___/___ Today's Date ___/___/___

Address of Child/Student _____ Town _____

Medication Name/Generic Name of Drug _____ Controlled Drug? YES NO

Condition for which drug is being administered: _____

Specific Instructions for Medication Administration _____

Dosage _____ Method/Route _____

Time of Administration _____ If PRN, frequency _____

Medication shall be administered: Start Date: ___/___/___ End Date: ___/___/___

Relevant Side Effects of Medication _____ None Expected

Explain any allergies, reaction to/negative interaction with food or drugs _____

Plan of Management for Side Effects _____

Prescriber's Name/Title _____ Phone Number (____) _____

Prescriber's Address _____ Town _____

Prescriber's Signature _____ Date ___/___/___

School Nurse Signature (if applicable) _____

Parent/Guardian Authorization:

- I request that medication be administered to my child/student as described and directed above
- I hereby request that the above ordered medication be administered by school, child care and youth camp personnel and I give permission for the exchange of information between the prescriber and the school nurse, child care nurse or camp nurse necessary to ensure the safe administration of this medication. I understand that I must supply the school with no more than a three (3) month supply of medication (school only.)
- I have administered at least one dose of the medication with the exception of emergency medications to my child/student without adverse effects. (For child care only)

Parent/Guardian Signature _____ Relationship _____ Date ___/___/___

Parent /Guardian's Address _____ Town _____ State _____

Home Phone # (____) _____ - _____ Work Phone # (____) _____ - _____ Cell Phone # (____) _____ - _____

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse (if applicable) in accordance with board policy. In a school, inhalers for asthma and cartridge injectors for medically-diagnosed allergies, students may self-administer medication with only the written authorization of an authorized prescriber and written authorization from a student's parent or guardian or eligible student.

Prescriber's authorization for self-administration: YES NO _____
Signature Date

Parent/Guardian authorization for self-administration: YES NO _____
Signature Date

School nurse, if applicable, approval for self-administration: YES NO _____
Signature Date

Today's Date _____ Printed Name of Individual Receiving Written Authorization and Medication _____

Title/Position _____ Signature (in ink or electronic) _____

Note: This form is in compliance with Section 10-212a, Section 19a-79-9a, 19a-87b-17 and 19-13-B27a(v.)