



As required by the State of Connecticut, a medical form is needed for every person (youth & adults) participating or staying in camp. This form requires a medical examination every 36 months (3years) with a yearly update by a parent/guardian (see section B) for people less than 40 years of age. For those 40 and over, a medical exam is required every 12 months (1 year).
SECTION A and SECTION B – YOU FILL OUT: SIGNATURE REQUIRED (Parent/Guardian if you are under 18)
SECTION C: (& D if applicable) – PHYSICIAN FILLS OUT (Signature required – See Reverse)

SECTION A: Personal Information & Health history

Camper's Name: Last First Sex M/F

Address: \_\_\_\_\_

Town: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_ Age: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Telephone Contact for Parent/Guardian: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Emergency Contact (Other than parent or guardian) Address: \_\_\_\_\_

Telephone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Relation) \_\_\_\_\_

Personal Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Insurance Carrier Address: \_\_\_\_\_

HEALTH HISTORY (X) KNOWN ALLERGIES (X) General Information (X)
Serious Illness\_\_\_ Serious Injury\_\_\_ Animal\_\_\_ Insect Toxin\_\_\_ Asthma\_\_\_ Seizure/Epilepsy\_\_\_ Diabetes\_\_\_
Deformity\_\_\_ Surgery\_\_\_ Drug\_\_\_ Foods\_\_\_ ADHD\_\_\_ Emotional Difficulty\_\_\_
Cancer\_\_\_\*Other\_\_\_ Plant\_\_\_\*Other\_\_\_ Cardiac\_\_\_ Blood Pressure\_\_\_
Bleeding Disorders\_\_\_ Mobility Difficulty\_\_\_
Glasses/Contacts\_\_\_ Denture/Orthodic\_\_\_

Please list below any equipment needed at camp: wheelchairs, braces, crutches, etc.

\_\_\_\_\_

\*Please explain details of above:

\_\_\_\_\_

\_\_\_\_\_

IMMUNIZATIONS: Provide Actual Date ("Up to Date" is not acceptable to the State Health Dept.)

Diphtheria/Tetnus/Pertusis (DTaP) 1 \_\_\_ 2 \_\_\_ 3 \_\_\_ 4 \_\_\_ 5 \_\_\_ Tetanus (Td) Booster \_\_\_
Polio (IPV or OPV please circle) 1 \_\_\_ 2 \_\_\_ 3 \_\_\_ 4 \_\_\_ Varicella 1 \_\_\_ 2 \_\_\_
Measles/Mumps/Rubella (MMR) 1) \_\_\_ 2) \_\_\_ Hepatitis B (Hep B) 1) \_\_\_ 2) \_\_\_ 3) \_\_\_
Tetanus/Diphtheria/Pertussis (Tdap-adolescent) Booster \_\_\_ Meningococcal (MCV4) \_\_\_
Pneumococcal (PCV) \_\_\_ Hepatitis A \_\_\_ Other \_\_\_

Please list: 1) ALL medications taken in the past 30 days prior to camp arrival 2) Any Physical or Behavior conditions that might affect or limit participation at camp:

\_\_\_\_\_

SECTION B: Medications, Yearly Update & Parent/Guardian Permission

PLEASE CAREFULLY READ THE FOLLOWING: If you disagree with any statements here, please cross out that section and initial it. Explain your wishes in the space provided, attaching additional sheet if necessary.

This medical form is correct so far as I know, and the person names in Section A has permission to participate in all camp activities except as noted on the form by me or on the reverse by the doctor. In case of accident, injury or illness while at camp, I hereby give my permission to the doctor selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery or injections of medications.

I hereby request that the prescription medication(s) listed on the reverse, ordered by the doctor/dentist for my child, be administered by the camp's Health Officer. I understand that I must supply the camp with the prescribed medication in the original container as dispensed and properly labeled by a doctor or pharmacist and will provide no more than is appropriate for my child's camp stay. I understand that this medication will be destroyed if not picked up within one week after my child leaves camp.

I give my permission for the camp Health Officer to administer over-the-counter medications as directed for conditions as dictated by the Camp Physician (The Connecticut Yankee Council's policy on medications at Scout camp has been formulated to comply with the National Standards of the Boy Scouts of America and the State of Connecticut Health Dept.) Over the counter medications may include: Sunscreen, topically as needed for sun exposure; Bug Repellant, topically as needed q 2-4 hrs.; Robitussin (Guifenesin), po, per weight/age dosing for cough as needed q 6 hrs.; Benadryl (Diphenhydramine), po, per weight/age dosing for rash/itch, as needed, q 4-6 hrs.; Maalox, po, per weight/age dosing for upset stomach, as needed OR Tums, po, per weight/age dosing for upset stomach, as needed; Kaopectate, po, per weight/age dosing for diarrhea, as needed q 4 hrs (NOT more than 2 consecutive doses); Milk of Magnesia, po per weight/age dosing for constipation, as needed q 6 hrs (NOT more than 2 consecutive doses); Tylenol (Acetaminophen), po, per weight/age dosing for pain, as needed q 4-6 hrs; Motrin (Ibuprofen), po, per weight/age dosing for pain as needed q 6-8 hrs; Throat Lozenge, po, 1 tab for sore throat q 2-4 hrs, as needed; Bacitracin, topically, for wound care/infection prevention, as needed; Calamine Lotion, topically, for itch/contact dermatitis, as needed, q 1 hr; EPI Pen (Auto Inject) & Benadryl (po, per weight/age dosing), for Anaphylactic Reaction (911 transport to E.R. for medical evaluation and follow-up)

YEAR 1 (2006)

Signature: \_\_\_\_\_

Adults over 18 sign here (Parent/Guardian signs for Camper)

Name (print): \_\_\_\_\_

Relationship: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Comment: \_\_\_\_\_

YEAR 2 (2007)

Signature: \_\_\_\_\_

Adults over 18 sign here (Parent/Guardian signs for Camper)

Name (print): \_\_\_\_\_

Relationship: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Comment: \_\_\_\_\_

YEAR 3 (2008)

Signature: \_\_\_\_\_

Adults over 18 sign here (Parent/Guardian signs for Camper)

Name (print): \_\_\_\_\_

Relationship: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Comment: \_\_\_\_\_

**SECTION C:**

Physical Examination to be completed by a licensed medical provider (a school medical form may be attached in place of Section C)

**PROVIDERS PLEASE NOTE:** Provider's signature below also authorizes administration of over the counter medications (listed in Section B) by the camp Health Officer. **Additional signature required in Section D, if prescription medications are involved.**

**DIRECTIONS:** Write in values where appropriate. Place a (X) for items examined and satisfactory, leave blank if not examined. If there are any abnormalities, please make a note below in the restriction/recommendations/comments section. Use more paper if needed and attach to this form.

Name of Person \_\_\_\_\_  
Examined: \_\_\_\_\_ Age: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ B.P.: \_\_\_\_\_ / \_\_\_\_\_ Pulse: \_\_\_\_\_ Hearing: *Right* \_\_\_\_\_ *Left* \_\_\_\_\_  
Vision: *Near* \_\_\_\_\_ *Far* \_\_\_\_\_ Glasses: Yes/No \_\_\_\_\_ Contacts: Yes/No \_\_\_\_\_

Growth/Development: \_\_\_\_\_ Skin/Glands/Hair: \_\_\_\_\_ Ears: \_\_\_\_\_ Head/Neck/Thyroid: \_\_\_\_\_  
Ears/Eyes/Nose: \_\_\_\_\_ Teeth/Tonsils: \_\_\_\_\_ Cardiovascular: \_\_\_\_\_ Respiratory: \_\_\_\_\_ Abdomen: \_\_\_\_\_  
Genitourinary: \_\_\_\_\_ Genitalia: \_\_\_\_\_ Musculoskeletal: \_\_\_\_\_ Neurobehavioral: \_\_\_\_\_  
Hernia: \_\_\_\_\_ Other (*specify*): \_\_\_\_\_

Activity Restrictions/ Diet Restrictions / Comments / Medical information pertinent to routine care and emergencies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The above named person is in satisfactory condition and may engage in all camp activities (**including Hiking, Boating, Swimming, Competitive Sports, Sleeping on Ground**) except where noted above.

Print Name of Medical Provider: \_\_\_\_\_

Office Address: \_\_\_\_\_

Phone: \_\_\_\_\_ State Licensed in: \_\_\_\_\_ License No: \_\_\_\_\_

Signature of Medical Provider: \_\_\_\_\_

Date Signed: \_\_\_\_\_

**SECTION D: Prescription Medications**

POLICY ON PRESCRIPTION MEDICATION AT CAMP:  
MUST BE UPDATED EVERY YEAR

To authorize administration of prescription medications to anyone at camp, this section of the medical form must be signed by the physician. Medications WILL NOT be administered unless the Camp Health Officer is in receipt of this form. Please attach a separate sheet if necessary. Thank you.

**YEAR 1:** Medications currently being taken: (2006)

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Route: \_\_\_\_\_ Time: \_\_\_\_\_

1) \_\_\_\_\_  
Side Effects/Cautions: \_\_\_\_\_

2) \_\_\_\_\_  
Side Effects/Cautions: \_\_\_\_\_

3) \_\_\_\_\_  
Side Effects/Cautions: \_\_\_\_\_

Physician signature: \_\_\_\_\_ Date: \_\_\_\_\_

**YEAR 2:** Medications currently being taken: (2007)

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Route: \_\_\_\_\_ Time: \_\_\_\_\_

1) \_\_\_\_\_  
Side Effects/Cautions: \_\_\_\_\_

2) \_\_\_\_\_  
Side Effects/Cautions: \_\_\_\_\_

3) \_\_\_\_\_  
Side Effects/Cautions: \_\_\_\_\_

Physician signature: \_\_\_\_\_ Date: \_\_\_\_\_

**YEAR 3:** Medications currently being taken: (2008)

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Route: \_\_\_\_\_ Time: \_\_\_\_\_

1) \_\_\_\_\_  
Side Effects/Cautions: \_\_\_\_\_

2) \_\_\_\_\_  
Side Effects/Cautions: \_\_\_\_\_

3) \_\_\_\_\_  
Side Effects/Cautions: \_\_\_\_\_

Physician signature: \_\_\_\_\_ Date: \_\_\_\_\_