Summer Place Programs
University of Hartford
200 Bloomfield Avenue
West Hartford, CT 06117
Phone 860.768.4432
Fax 860.768.4233

2017 Summer Place Camper Medical Record

The State of Connecticut requires that all campers submit an up-to-date medical record.
The completed and signed medical form must be returned to us by May 1, 2017.

This side should be completed by parents/guardians of campers. The reverse side is to be completed and signed by your child's physician, and may be based on an exam conducted any time since **August 4, 2014.**

If medication needs to be administered while your child is at camp, contact the Summer Place office (860-768-4432) to receive an *Authorization of Medication* form. Medicines with specific instructions can be dispensed from the nurse's office.

Camper Name_____Sex_____Birth Date_____Grade(fall'17)_____

Camper's Current School _____Location of School _____

Home Address_____

Parent/Guardian Phone Numbers:

Name _____Home_____Cell_____Work_____

Name _____Home_____Cell_____Work_____

Indicate program/session(s) your child is enrolled in:

Summer Place	Session I ❑	Session II ❑	Session III ❑
SPLIT	Session I ❑	Session II ❑	Session III ❑
KinderPlace/ Li'l Place	Session I ❑	Session II ❑	Session III ❑

Allergies: List all known _____

This camper has the following issues which may affect his/her camp experience:

☐ Vision ☐ Auditory ☐ Speech/Language ☐ Physical Dysfunction ☐ Emotional/Social ☐ Behavior

Disability or chronic or recurring illness _____

Is there any other health related information that should be shared with appropriate staff members?

_____

Please indicate which, if any, of the following your child may be given at camp.

Acetaminophen _____Ibuprophen _____ Benadryl _____Calamine _____ Antibiotic Ointment _____

Insect Repellent _____Sunscreen _____

PERMISSION TO PARTICIPATE AND AUTHORIZATION FOR EMERGENCY TREATMENT

To the best of my knowledge, this health history is correct. My child has my permission to participate in all camp activities (including the evening program) except as noted by me or the examining physician. Also, Summer Place has made me aware of its policies regarding concussions. If I cannot be reached in an emergency, I hereby authorize the physician selected by the Camp Director to hospitalize, secure proper treatment for, and order injections and/or anesthesia for surgery for my child, as deemed necessary.

Signature (Parent/Guardian)_____ Date _____

Over please

Name of Camper_____ **Date of Exam**_____

TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER:

This camper is up-to-date on all the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and National Advisory Committee on Immunization Practices:

	Yes	No		Yes	No
Measles			Hepatitis B		
Mumps			Diphtheria		
Rubella			Pertussis		
Chickenpox			Polio		
Tetanus			Pneumococcal Conjugate Vaccine		

This camper has the following issues which may affect his/her camp experience:

☐ Vision ☐ Auditory ☐ Speech/Language ☐ Physical Dysfunction ☐ Emotional/Social ☐ Behavior

☐ The camper has a health condition which may require emergency action at camp, e.g., seizures, allergies, anaphylaxis. *Specify below.*

Comments:_____

_____

_____

_____

Is this individual taking prescription medication? ☐YES ☐NO

If yes, indicate medication:_____

Does the individual have allergies? ☐ YES ☐ NO Explain:_____

Is the individual on a special diet? ☐ YES ☐ NO Explain:_____

May participate in all camp activities _____

May participate except for: _____

_____

Medical information pertinent to routine care and emergencies: _____

Print name of medical care provider: _____

Medical care provider's address: _____

City/Town _____ ST _____ Zip Code_____

_____

Signature of Physician, APRN or PA

_____

Date Form Signed

_____

Telephone Number