



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

2018 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, 2018.**

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 3, 2015**.

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'18) _____

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 <input type="checkbox"/> | Session II <input type="checkbox"/> | Session III <input type="checkbox"/> |
| SPLIT | Session I <input type="checkbox"/> | Session II <input type="checkbox"/> | Session III <input type="checkbox"/> |
| KinderPlace/ Li'l Place | Session I <input type="checkbox"/> | Session II <input type="checkbox"/> | Session III <input type="checkbox"/> |

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 _____

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