Channel 3 Kids Camp
73 Times Farm Rd. Andover, CT 06232
(860)742-2267
www.channel3kidscamp.org

Physician's Form

This form must be completed in its entirety and received before your child can be enrolled in camp.

Child's Name _____ Date of Birth _____/_____/_____
Address _____
Parent/Guardian Name_____ Relationship to Child _____
Address (if different from child)_____
Home Phone (_____)_____-_____Cell Phone (_____)_____-_____ Work Phone (_____)_____-_____

This section must be filled out by a physician, PA, or APRN. A school physical form may be used.

Immunization History: include all dates of basic immunizations and most recent boosters. (A vaccination history may be attached, but must include all information)

Dtap	1st	2nd	3rd	4th 5th
HiB	1st	2nd	3rd	4th
PCV	1st	2nd	3rd	4th
IPV	1st	2nd	3rd	4th
HBV	1st	2nd	3rd	
Rotavirus	1st	2nd	3rd	
MMR	1st	2nd		
Varicella	1st		**Other:**	**Date**

Physical Examination

	Satisfactory	Not Satisfactory	Not Examined	Details
HEENT	☐	☐	☐	_____
Mental Health	☐	☐	☐	_____
Heart	☐	☐	☐	_____
Lungs	☐	☐	☐	_____
Abdomen	☐	☐	☐	_____
Genitourinary	☐	☐	☐	_____
Extremities	☐	☐	☐	_____
Posture/Spine	☐	☐	☐	_____
Metabolic	☐	☐	☐	_____

Additional Health Information _____
Application is under the care of physicians for the following conditions_____
_____
General Appraisal of Patient_____
Restrictions for camp ☐ None Other_____

I have examined the person herein described and reviewed the health history. It is in my opinion that the child is physically able to participate in camp activities except as noted above. I attest that this child has had a physical within the last 2 years.

Dr./PA/APRN Name _____
Address _____
Phone _____Fax _____
Practitioners Signature_____
License Number _____

Last Exam Date:
_____/_____/_____
Must be within 2 years of camp attendance

FORM 1

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Authorization for the Administration of Medication Form

This form must be completed by a Physician, PA, or APRN if your child will be bringing prescribed medication to camp. This form must be received by camp prior to your child's attendance. Copy form as needed to list all prescriptions. **All medications must be sent in the original containers with the dosage instructions provided and a signed order from a Provider.**

Parents/Guardians: Please complete all fields in this top section.

Child's Name_____ Date of Birth____/____/____

Parent/Guardian Name_____ Relationship to Child _____

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

Food Allergies Yes / No If yes, please describe_____

Medical Allergies Yes / No If yes, please describe _____

The section below is to be completed by the prescribing Physician, PA, or APRN.

Prescribed Medication	Dose	Frequency	Route	Indication/ Condition	Controlled Y/N	Side Effects	Plan for Side Effects

Camp standard medication times are 8am, 12pm, 3pm, 6pm, and 8pm. Other times are available if necessary.

Orders are effective 1/1/21-12/31/21

Dr./PA/APRN Name_____ Date_____

Address_____

Phone_____ Fax_____

Practitioners Signature_____ License Number_____

All fields in this box must be completed by the prescriber.

Individual Plan of Care for a Child

With Special Health Care Needs or Disabilities

Child's Name:_____ Date of Birth_____/_____/_____

Special health care need or disability:

Plan for appropriate care of the child in a medical emergency. An individual Plan of Care is necessary when a child has a special health care need or disability and it is necessary that special care be taken or provided while the child is at the youth camp.

Other relevant information: (e.g. precautions to be taken to prevent a medical or other emergency)

Signature(s) of the Parent(s):	Date Signed:
_____	____/_____/_____
_____	____/_____/_____

NOTE: Section 428-3(a) requires a child's health record to include information regarding disabilities or special health care needs such as allergies, special dietary needs, dental problems, hearing or visual impairments, chronic illness, developmental variations or history of contagious disease, and an individual plan of care for the child with special health care needs or disabilities. The plan shall be developed with the child's parent(s) and health care provider and updated as necessary. Such plan of care shall include appropriate care of the camper in the event of a medical or other emergency and shall be signed by the parent(s) and staff responsible for the care of the camper.

Please use the reverse side of this form for signature(s) of all staff responsible for the care of this child.