



HEALTH EXAM / RECORD

Physical exams are valid for 3 years
from date of the last examination

Please mail/fax the completed form prior to the start date of camp

Camper
Staff

Name: _____ Date of Birth: ____/____/____ Phone: (____) _____

Guardian: _____ Address: _____

Emergency Contact: _____ Telephone: (____) _____

Camp Location: _____ Date of Arrival at camp: ____/____/____ Departure Date: ____/____/____

TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER

DATE OF EXAM

- May participate in all camp activities
 May participate except for _____

Medical information pertinent to routine care and emergencies _____

Is this individual taking prescription or over the counter medications? YES NO

(If yes, please indicate names of medications) _____

Does the individual have allergies? YES NO Explain: _____

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

Does the individual have special needs? YES NO Explain: _____

This camper/staff 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		YES / NO	
Measles	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Diphtheria	<input type="checkbox"/>	<input type="checkbox"/>
Rubella	<input type="checkbox"/>	<input type="checkbox"/>	Pertussis	<input type="checkbox"/>	<input type="checkbox"/>
Chickenpox	<input type="checkbox"/>	<input type="checkbox"/>	Pneumococcal conjugate	<input type="checkbox"/>	<input type="checkbox"/>
				Tetanus	<input type="checkbox"/>
				Polio	<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>

Comments: _____

Print name of medical care provider: _____ Address: _____

_____ City/Town: _____ State: _____ Zip: _____

Date: _____ Telephone: (____) _____

Signature of Physician, PA, APRN or RN _____

DATE OF EXAM: ____/____/____

SCAN/EMAIL: graeme.lloyd@soccerextreme.com

MAIL: Soccer Extreme, 644 Danbury Road, Wilton, CT, 06897 FAX: (909) 793-7310



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Authorization for the Administration of Medication

In Connecticut, licensed Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the CT State Statutes and Regulations. Parents/guardians requesting medication administration to their child while at camp 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. All unused medication shall be destroyed if not picked up within one week following the camper's departure at the end of camp.

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

Name of Child _____ Date of Birth ____/____/____ Today's Date ____/____/____

Medication Name _____ Controlled Drug? YES NO

Dosage _____ Method _____ Time of Administration _____

Specific Instructions for Medication Administration _____

Medication Administration: Start Date ____/____/____ Stop Date ____/____/____

Is this medication to be self-administered by the child? YES NO

Relevant Side Effects of Medication _____

Plan of Management for Side Effects _____

Known Food or Drug Allergies? YES NO Reactions to? YES NO Interactions with? YES NO

If "yes" to any of the above, please explain _____

Prescriber's Name _____ Phone Number (____) _____

Prescriber's Address _____ Town _____

Prescriber's Signature _____

Parent/Guardian Authorization:

I request that medication be administered to my child as described and directed above.

Name of Camp _____ Today's Date ____/____/____

Child's Name _____ Address _____ Town _____

Name of Parent/Guardian Authorizing Administration of Medication as described and directed above:

First Name _____ Last Name _____

Relationship to Child: Mother Father Guardian/Other explain: _____

Address _____ Town _____ Phone Number (____) _____

Signature of Parent/Guardian Authorizing Administration of Medication _____

Name of Camp Personnel Receiving Written Authorization and Medication _____

Title/Position _____ Signature (in ink) _____



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Medication Administration Record (MAR)

Name of Child _____ Date of Birth ____/____/____

Pharmacy Name _____ Prescription Number _____

Medication Order _____

Date	Time	Dosage	Remarks	Was This Medication Self Administered?	Signature of Person Observing or Administering Medication
				<input type="checkbox"/> YES <input type="checkbox"/> NO	
				<input type="checkbox"/> YES <input type="checkbox"/> NO	
				<input type="checkbox"/> YES <input type="checkbox"/> NO	
				<input type="checkbox"/> YES <input type="checkbox"/> NO	
				<input type="checkbox"/> YES <input type="checkbox"/> NO	
				<input type="checkbox"/> YES <input type="checkbox"/> NO	
				<input type="checkbox"/> YES <input type="checkbox"/> NO	
				<input type="checkbox"/> YES <input type="checkbox"/> NO	
				<input type="checkbox"/> YES <input type="checkbox"/> NO	
				<input type="checkbox"/> YES <input type="checkbox"/> NO	
				<input type="checkbox"/> YES <input type="checkbox"/> NO	

*Medication authorization form must be used as either a two-sided document or attached first and second page.

- Authorization form is complete
- Medication is in original container
- Medication is appropriately labeled
- Date on label is current

Person Accepting Medication (print name) _____

Date ____/____/____