

Incarnation Camp

A : PO Box 577, Ivoryton, CT 06442

P : 860-767-0848

E : Healthcenter@incarnationcamp.org

F : 860-767-8432

STAFF MEMBER INFORMATION

Full Name :

Date of Birth : / /

Gender :

Age at Camp:

Address

City State Zip



A staff member with a chronic disease or medical condition may possess and self-administer prescribed medication for the disease or condition if the Staff member (or if the staff member is under the age of 18 a parent/guardian) has filed a written authorization with the camp nurse. The written authorization must be filed annually and must include the following information.

1. A physician's statement that the staff member has an acute or chronic disease or medical condition for which medication has been prescribed.
2. The nature of the disease or medical condition requiring emergency administration of the prescribed medication.
3. The staff member has been instructed in how to self-administer the prescribed medication.
4. The staff member is authorized to possess and self-administer the prescribed medication by their physician.
5. If the staff member is under the age of 18 they have been authorized to possess and self-administer the prescribed medication by the parent/guardian.

This section of the form is only for staff members who must keep epi-pens or other emergency medications on their person.

PERMISSION FOR SELF-ADMINISTRATION OF MEDICATION (IF NECESSARY)

Medical Condition

Drug Allergies

Medication

Dosage/Time/Interval

☐ The staff member has been instructed on how to self-administer and is authorized as signed below to self administer the prescribed medication.

Physician Signature Physician Printed Name Date

The staff member accepts legal responsibility for the safe transport of their own medication to and from camp. The camp nurse may contact the staff member's physician if there are questions regarding the use of this medication. It is the responsibility of the staff member to maintain a supply of the medication for themselves

Staff Member Signature Staff Member Printed Name Date

If the staff member is under the age of 18 the Parent/Guardian accepts legal responsibility for the safe transport of the staff member's medication to and from camp. The camp nurse may contact the staff member's physician if there are questions regarding the use of this medication. It is the responsibility of the parent/guardian to maintain a supply of the medication for the staff member.

Parent/Guardian Signature Parent/Guardian Printed Name Date



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Staff Member
Name

RECORD OF HEALTH EXAM BY LICENSED MEDICAL PERSONNEL

To be filled out by Physician

DATE OF LAST EXAM :

In my opinion the above applicant ☐ is ☐ is not able to participate in an active camp Program.

BP

Weight

Height

Please note any conditions or findings considered abnormal or requiring medical follow up.

Medications Being Taken

Please list all prescription drugs taken routinely. Keep In original packaging/bottle that identifies the prescribing physician, name of medication, dosage, and frequency of administration

MED #1

Dosage

Reason

MED #2

Dosage

Reason

MED #3

Dosage

Reason

Please Identify any medications taken during the fall through spring only

Recommendations and Restrictions at Camp

Treatment to be continued at camp

Dietary Restrictions (including
lactose Intolerance)

Allergies

Any Limitations or restrictions of
camp activities

Staff Members will not be admitted to camp without a health form signed by licensed medical personnel.

Address of Licensed
Medical Personnel

Title

Phone

Email

Fax

Licensed Medical Personnel
Signature

Licensed Medical Personnel
Printed Name

Date



Please return this form to the Health Center office
via upload to CampBrain, Email, Fax or Mail

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Staff Member
Name

AUTHORIZATION FOR NON-PRESCRIPTION DRUG ADMINISTRATION

To be filled out by Staff Member and Physician (or Parent/Guardian if applicable)

There may be times at camp when a staff member will ask for non-prescription medications to help relieve symptoms related to minor conditions such as poison ivy, headache, or upset stomach. A Registered Nurse (RN) at the Health Center can assess the staff member's condition and dispense the appropriate medications.

Staff Member Name

Address

City

State

Zip

Topical

Calamine or Caladryl lotion, Hydrocortisone 1% Cream

Hydrogen Peroxide

Kenalog Cream

Lidocaine Topical Ointment

NIX Crème Rinse

Normal Saline Solution

Proxigel or Similar Canker Sore Medication

Silvadene Cream

Tinactin or similar antifungal powder, spray or cream

Triple Antibiotic Ointment

Eardrops

Tinactin or similar antifungal powder, spray or cream

Triple Antibiotic Ointment

Oral

Benadryl

ChlorTrimeton (Allergy, Decongestant)

Chloroseptic Spray or Lozenges

Dimetapp (Decongestant)

Kaopectate

Maalox

Milk of Magnesia

Mortin (Ibuprofen)

Pepto-Bismol (Bismuth Subsalicylate)

Robitussin DM (Cough Suppressant)

Sudafed (Pseudoephedrine)

Tums (Calcium Carbonate)

Tylenol (Acetaminophen)

Other

We give permission for a Registered Nurse or Staff Member trained in accordance with the State of Connecticut Health Department regulations to administer medications as indicated above in accordance with the label directions and with attention to the relevant side effects also listed on the label of above medications.

If the staff member is under the age of 18 the Parent/Guardian gives permission for a Registered Nurse or Staff Member trained in accordance with the State of Connecticut Health Department regulations to administer medications as indicated above in accordance with the label directions and with attention to the relevant side effects also listed on the label of above medications.

Staff Member Signature

Staff Member Printed Name

Date

Physician Signature

Physician Printed Name

Date

Parent/Guardian
Signature

Parent/Guardian
Printed Name

Date

