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HEALTH RECORD

MUST BE FILLED OUT BY PARENT/GUARDIAN IN ADDITION TO SUBMIT COPIES OF LATEST PHYSICAL EXAMINATION, SUPPLEMENTS, VACCINATIONS, and INSURANCE CARD

Camp: ____

Camper Name: ____
Last First M.I.

DOB: ______/______/_______ Gender____________ Age while in camp: ________________

Parent/Guardian:

Name____ Relation to Child: __________
Last First

Address: ____
Street Town/City State Zip

Phone (Day): (______) ______-_________ Phone (Evening): (____) _____-________

Health History: Provide dates and other information requested or indicate N/A.

Ear Infections	_____	Chicken Pox	_____	Measles	_____
Convulsions	_____	German Measles	_____	Diabetes	_____
Mumps	_____	Bleeding Disorder	_____	Tuberculosis	_____

Allergies: ____

Operations/serious injuries: ____

Disability or chronic or recurring illness: ____

Current medications____

Name of dentist/orthodontist: ______________________________ Phone #______________

Name of physician: _____________________________________ Phone #______________

Signature of Parent/Guardian: _______________________________ **Date**: _____________

Office of Conferences & Special Events
263 Alden Street, Springfield, MA 01109
Email: specialevents@springfieldcollege.edu
Telephone (413) 748-5287 Fax (413) 731-3412

*IMPORTANT: Please attach a copy of Health Insurance Card (front and back)

IMMUNIZATIONS: THIS SECTION MUST BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER OR ATTACH A COPY OF IMMUNIZATION DOCUMENTATION OR ALTERNATIVE PROOF OF IMMUNITY.

REQUIRED IMMUNIZATIONS (Campers under 18)	DATE (Month/Day/Year)
MMR (1st dose age 12 months or older)	
Measles #2 or MMR #2 (Given at age 4-6)	
Polio (3 doses of OPV or IPV or 4 doses of mix IPV or OPV)	#1 #2 #3 #4
Diphtheria and Tetanus Toxoids and Pertussis	#1 #2 #3 #4 Booster (if applicable)
Hepatitis B (3 doses if born on or after January 1, 1982)	#1 #2 #3

LEAD SCREENING: ____

Effective 3/01/90 Massachusetts State Law requires all children, regardless of risk, to be screened at least once between ages of 9-12 months and annually until the age of 48 months. Children under 3 years who are determined to be at high risk for lead exposure must be screened every 6 months, and yearly from 3 years to 6 years. Children must present evidence of having been previously screened as a condition for entry to kindergarten.

Physical examination by a physician: This section must be completed by a physician or attach a copy of a physical examination conducted by a medical provider during the preceding 24 months.

Height:	Eyes:	Abdomen:
Weight:	Vision:	Genitalia, Hernia:
BP:	Ears, Nose, Throat:	Musculoskeletal:
HCT or Hgb:	Heart:	Neurological Exam:
Urinalysis:	Lungs:	Skin:

DATE OF LAST PHYSICAL EXAM: ____

Recommendation for camp participation:

- Is participant capable of participating in active camp programs? ☐ **YES** ☐ **NO**
- Please explain any restrictions____
- Is participant currently taking medications?
  ____
  ____
  ____
- List any medications to be administered by Camp Health Supervisor:
  ____
  ____
  ____

Signature of Health Care Provider: ___________________________________ **Date**: ____________

Printed Name of Health Care Provider: ____

Office Address: ____ **Phone**: ___________

*Important Required Health Record Document Checklist:

___1. Copy of latest physical examination conducted by a physician or medical provider during the preceding 24 months

___2. Copy of immunization records is attached

___3. Completed forms, and/or attached supplemental documentation

___4. Complete and Sign the Authorization to Administer Medication form on the next page regardless if camper is taking medication. If so say N/A

___5. Copy of the camper’s Health Insurance Card (front and back)

AUTHORIZATION TO ADMINISTER MEDICATION TO A CAMPER

Required Information to be completed by parent/guardian – Please Print

CAMP NAME:_______________________________________ Name of camper:_______________________________________
Last Name *First Name*

DOB:_____________________ Parent/guardian name:_______________________________________
(PLEASE PRINT) *Last Name* *First Name*

*Food/drug allergies:_________________________________ Home telephone:_____________________________

*Does camper take any prescription Medication ____Yes ____No (If no, scroll down to page 2 and sign.)

Diagnosis (*at parent's discretion*):___________________________ Work telephone:_____________________________

____ Emergency telephone:_________________________

Name of licensed prescriber:_________________________ Work telephone:_____________________________

Emergency telephone:_________________________

Name of medication:_________________________________ Dose to be given at workshop: __________________

How to administer:___________________________ Frequency:____________ Date ordered:______________

Duration of order:_____________ Quantity received:____________ Expiration date of medication received:_______

Special storage requirements:____

Specific directions (e.g., on empty stomach/with water):____

Specific precautions:____

Possible side effects/adverse reactions:____

Other medications (at parent's discretion):____

Location where medication administration will occur:____

AUTHORIZATION TO ADMINISTER MEDICATION TO A CAMPER

I hereby authorize **Springfield College's Health Care staff** to administer to my child, ______________________________, the
First Name, Last Name
medication(s) listed above, in accordance with 105 CMR 430.160. (Minimum standards for recreational Camps for Children)

430.160: Storage and Administration of Medication
(A) Medication prescribed for student shall be kept in original containers bearing the pharmacy label, which shows the date of filling, the pharmacy name and address, the filling pharmacist's initials, the serial number of the prescription, the name of the patient, the name of the prescribing practitioner, the name of the prescribed medication, directions for use and cautionary statements, if any, contained in such prescription or required by law, and if tablets or capsules, the number in the container. All over the counter medications for student shall be kept in the original containers containing the original label, which shall include the directions for use.
(B) All medication prescribed for student shall be kept in a locked storage cabinet used exclusively for medication, which is kept locked except when opened to obtain medication. The cabinet shall be substantially constructed and anchored securely to a solid surface. Medications requiring refrigeration shall be stored at temperatures of 38° to 42°F in a locked box, used exclusively for medications, and physically affixed to the refrigerator.
(C) Medication shall only be administered by the health supervisor or by a licensed health care professional authorized to administer prescription medications. If the health supervisor is not a licensed health care professional authorized to administer prescription medications, the administration of medications shall be under the professional oversight of the health care consultant. The health care consultant shall acknowledge in writing a list of all medications administered at the camp. Medication prescribed for campers brought from home shall only be administered if it is from the original container, and there is written permission from the parent/guardian.
(D) When no longer needed, medications shall be returned to a parent or guardian whenever possible. If the medication cannot be returned, it shall be destroyed as follows:
(1) Destruction of prescription medication shall be accomplished by the health care consultant, witnessed by a second person and recorded in a log maintained by the camp for this purpose. Said log shall include the name of the camper, the name of the medication, the quantity of the medication destroyed, and the date and method of destruction. The health care consultant and the witness shall sign each entry in the medication destruction log.
(2) The medication log shall be maintained for at least three years following the date of the last entry.
430.159: Health Care Staff to be provided
(C) A health supervisor, who is at least 18 years of age, is present at the workshop at all times. The health supervisor shall be a Massachusetts licensed physician, physician assistant, nurse practitioner, registered nurse, licensed practical nurse, or other person specially trained in first aid. First aid training shall mean at least current certification in American Red Cross Standard First Aid, or its equivalent and CPR. Primitive, Travel, and Trip Camps shall have at least one individual in addition to the health supervisor accompanying the students, who is adequately trained to render first aid. Said individual shall possess at least current certification in Red Cross Standard First Aid, or its equivalent.

Parent/Guardian Name: ____
(PLEASE PRINT)

Parent/Guardian Signature:____ **Date:**_________________

Witness Name: ____
(PLEASE PRINT)

Witness Signature: ____ **Date:** __________________

SPRINGFIELD COLLEGE / Office of Conferences and Special Events

PARENT/GUARDIAN AUTHORIZATION

Camp Name: ____

Camper Name: ____
Last Name First Name

Authorization to Participate/Assumption of Risk: I understand and certify that my child's participation at Springfield College and its activities is completely voluntary and I have familiarized myself with the program and activities in which my camper will be participating. I recognize that certain hazards and dangers are inherent within the program.
I acknowledge that although Springfield College has taken safety measures to minimize the risk of injury to participants, Springfield College cannot insure nor guarantee that the participants, equipment, premises, and/or activities will be free of hazards, accidents, and/or injuries. I further recognize and have instructed my camper in the importance of knowing and abiding by the camp's rules, regulations, and procedures for the safety of camp participants. If camp rules are not followed, my camper may be sent home.

Parent/Guardian:
SIGNATURE ____ **DATE** ___________________

Health Record Authorization: The health history for my camper is correct, and the participant has my permission to engage in all camp activities except as noted by me and/or the examining physician. This form may be shared with the Health Department. I also give permission for my camper's medical records to be photocopied for Health Department Records.

Parent/Guardian:
SIGNATURE ____ **DATE** ___________________

Emergency Authorization: I hereby give permission to the physician selected by a representative of Springfield College to order x-rays, routine tests, and treatment for the health of my camper. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by a representative of Springfield College to hospitalize, charge my health insurance, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my camper as named above.

Parent/Guardian
SIGNATURE ____ **DATE** ___________________

Print Name: ____
WITNESS
SIGNATURE ____ **DATE** ___________________

Print Name: ____

This form must be witnessed at the time of signing by another individual. If, for religious reasons, you cannot sign this form, contact us for a legal waiver, which must be signed to allow attendance.

SPRINGFIELD COLLEGE

Office of Conferences and Special Events

CAMPER PICK UP AUTHORIZATION

CAMP NAME: ____

CAMPER NAME: ____
Last Name First Name

The camp staff **will not** release a camper to anyone not listed on this release form, which must be signed by a parent/guardian**.**

Until staff members are able to recognize you and the people who will be picking up your camper, staff may ask for a picture identification, which will be cross referenced with the information submitted on this form. This is the only way that we can be certain that we are releasing your camper to the appropriate individual(s).

If a person's name does not appear on this form, the camper will not be released. *A note may be sent in with your camper on a day a new individual picks camper up. Please advise anyone picking up your camper of this policy and our photo identification requirement.*

Please remember to include yourself in the list of individuals when you complete this form.

The following people have permission to pick up my camper are:

PRINT FIRST NAME, LAST NAME	PRINT RELATIONSHIP TO CAMPER:
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Parent/Guardian Name: ______________________________________
(PLEASE PRINT)

Parent/ Guardian Signature: ____________________________ Date: ____________________________

THIS FORM IS NOT VAILD UNLESS SIGNED