

HEALTH FORMS

A health history is required for each camper. Please turn in **original and one copy** of health forms upon arrival. (See health forms) Information should include any physical condition, medications or allergies requiring special consideration. For a camper under 18 years of age, written consent for emergency medical care is required. **Be certain that parents have signed and given permission for treatment if the child needs to be treated at the emergency room.**

YOU MUST BRING THE SIGNED COPY OF THE HEALTH FORM WITH YOU TO THE EMERGENCY ROOM IF YOU TRANSPORT A CHILD TO THE EMERGENCY ROOM! IF THE CHILD LEAVES IN THE AMBLULANCE BE CERTAIN TO SEND A COPY OF THE HEALTH FORM WITH THE PARAMEDICS!

MEDICATIONS

All medications brought to camp must be in original containers.

An adult leader of the group shall keep all medications brought to camp by anyone under 18 years of age in a locked unit. The adult leader shall be responsible for the administration of the medications.

Bee sting medication, inhalers, insulin syringes, other medications or devices used in the event of life-threatening situations may be carried by a camper or staff member.

Each camper or staff member 18 years of age or older may take responsibility for the security of his or her personal medication.

MEDICATION / TREATMENT RECORDS

THE HEALTH CARE SUPERVISOR MUST SIGN EACH HEALTH FORM IN THE BOX IN THE UPPER RIGHT CORNER TO ACKNOWLEDGE THAT THE HEALTH FORMS HAVE BEEN REVIEWED. When a medication is administered or treatment provided, the adult leader shall make a record of the action on the chart on camper's health form listing name of the medication or treatment; ailment; dosage; date and time administered; by whom administered; and comments.

The group leader should retain the health forms and treatment records for at least 2 years.

BOSTON SCHOOL FOREST REGISTRATION HEALTH FORM

____ Reviewed by Group
Health Supervisor
(Please Check)
Name: _____

~~Youth~~ organizations using the school forest **must** use this form. This health information must be on file at the school forest during the time that the group is using the facility. This form must be kept by the youth group leader for 2 years.

Name _____ Age _____ Phone _____

Address _____ City _____ State _____ Zip _____

Organization _____ Date of Program _____

Emergency Contact Person _____ Phone _____

Insurance Company _____ Identification Number _____

Does the camper take any medication(s)? Yes _____ No _____ (see below)

My child has my permission to receive emergency medical care:

Parent/Guardian Signature

All prescription medications must be brought to camp in their ORIGINAL CONTAINER. THE CONTAINER MUST BE LABELED BY THE PHARMACY WITH THE CURRENT DOSAGE. Any changes from those on the container must be verified in writing by a physician. All vitamins, over the counter medication, preparations and homeopathic remedies must be brought in their original containers. The Health Care Staff is required to dispense medications as directed by a physician.

1. All medications (including over the counter pills, vitamins and treatments) must be turned over to the health care supervisor upon registration.
2. All medications will be administered under the direction of the health care staff.
3. All medications should be labeled clearly with the camper's name, name of the drug, dosage and time to be taken. Please provide an adequate supply.
4. Do not record insulin schedule below.

Name of Medication/Treatment	Ailment	Dosage	Date	Time	Date	Time	Name of whom administered

Comments: _____

5. Does the camper experience any side effects from the medication?
 Yes _____ No _____ (i.e.: mood or behavior changes, upset stomach, diarrhea, etc.)
 If yes, what should be done about this? _____
6. List below any special instructions or additional information regarding the medication that would be helpful to the health care supervisor. _____

7. **Allergies:** Do you have any allergies (e.g. bees, drugs, food, etc.)? If so, what are they?

8. **Medications:** Are you taking medication (e.g. Tylenol, Orthonovo 777, Proventil, etc.)? If so, what are they? What are they for? _____

9. **Chronic Illness:** Do you have any chronic illness (e.g., diabetes, epilepsy, asthma, etc.)? _____

10. **Physical Conditions:** Do you have any physical conditions that might limit or prevent you from participating in certain physical activities? If so, please describe. _____

11. **Injuries:** Have you experienced any injuries (e.g. dislocations, sprains, etc.) within the last three years? If so, list here and identify when the injuries occurred and the extent or the severity of the injury. Have you fully recovered from this injury? _____

12. **Physician:** Have you been treated by a physician in the past year? Have you been hospitalized within the past year? If so, explain. _____

Have you had any of the following in the last 24 hours?

	Yes	No	Explain
Fever			
Vomiting			
Dizziness			
Sore Throat			
Cough			