

Form Checklist for Parents

Please return all applicable forms as soon as possible

No camper may begin camp without completed medical forms

Print all forms, complete and return them to:

INTENSITY Squash Camp
490 Westport Ave, Norwalk CT 06851

- **Medical Forms Cover Sheet**
- **Medical Form**
- **Non-Prescription Form**
- **Prescribed Medication Form**
- **Confidential/Disclosure Statement**
- **Behavior Contract**

MEDICAL FORMS COVER SHEET

Paper clip / staple forms 1, 2 & 3 together & give the packet to the physician when camper gets his / her physical exam.

Follow steps 1 thru 5 below:

- 1. Medical Form** completed & signed by physician & parent.
- 2. Non-Prescription Authorization Form** initialed & signed by physician & parent. Physician & parent must initial each permitted medication.
- 3. Prescribed Medication Authorization Form** signed by physician & parent. Only send back this form if prescribed medication is to be taken at camp.
- 4. Health Insurance Card:** Please attach a front & back copy of the family's health insurance card when returning medical forms to us.
- 5. Head Lice:** Please check at doctor's office & right before sending child to camp! We screen campers for head lice upon arrival at camp. Campers with lice will be sent home.

MEDICAL FORM

Instructions * Please be sure to complete the PARENT SECTION: then give this form to your physician.

return before camp begins to:
INTENSITY Squash Camp
490 Westport Ave, Norwalk CT 06851

PARENT SECTION: *Though the likelihood of an emergency at camp is small, all information noted here must be provided. If details of your child's medical history are unclear, please have the physician assist you in completing both sides of this sheet. Authorizations must be signed to guarantee attendance at camp. Thank you.*

Camper Name		Date of Birth		Sex	M / F	Camp	Jun-24 / Jun-29
Parent Name		Parent Name		Phone 1		Phone 1	
Phone 1		Phone 2		Phone 2		E-mail	
Phone 2		E-mail		Address		Address	
E-mail		Address		City / State / ZIP		City / State / ZIP	
Address		Child's Physician		Emergency Contact		Phone 1	
City / State / ZIP		Phone		Phone 2		E-mail	
*Please attach address/phone of all specialists caring for your child				Address		City / State / ZIP	
Do you carry family medical/hospital insurance?	Y / N						
Carrier / Plan							
Group #							
Name of Insured (parent/guardian)							
Carrier Address							

Parent Authorizations * The health history below is correct as far as I know, and the person herein described has permission to engage in all camp activities except as noted...I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment, to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer hospitalization, injections, anesthesia, surgery, and/or any other proper treatment for the person named above...This form may be copied for trips out of camp.

PARENT SIGNATURE



Date _____

Health History to be completed by Parent * the intent of this information is to provide camp health care personnel and counselors the background to provide appropriate ongoing and emergency care. In completing this form it is assumed that the camp directors will be provided with any and all updated medical information right up to the first day of camp.

Medications (including vitamins) taken routinely. * if reaction. additional meds, note on attached page.			
Camper takes NO routine medications		Y / N	
Medication #1			
Dosage		How often each day	
Reasons for taking:			
Medication #2			
Dosage		How often each day	
Reasons for taking:			

Allergies to medications, and reaction: * Please describe reaction and management of Use additional page if necessary.
Allergies to food, and reaction:
Other allergies (insect stings, hay fever, asthma, animals)

MEDICAL FORM

PARENT SECTION Continued...

Camper Name _____

Restrictions * Please discuss these in detail on an attached page.			
Dietary:			
Physical activity to be restricted:			
Contagious diseases	Yes	No	Date (if "Yes")
Measles	<input type="checkbox"/>	<input type="checkbox"/>	
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	
German Measles	<input type="checkbox"/>	<input type="checkbox"/>	
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	
Additional Information about the participant's physical or mental health about which we should be aware - can be provided below or on an attached page.			

General Questions ('you' refers to camper)	Yes	No
1) Have you ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>
2) Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
3) Have you any chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>
4) Have you had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
5) Have you ever passed out during/after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
6) Have you ever been dizzy during/after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
7) Have you ever had chest pain during /after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
8) Have you ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
9) Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
10) Have you ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>
11) Have you ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>
12) Do you have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
13) Have you ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>
14) Do you have epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>
15) Do you have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
16) If female, is menstrual history abnormal?	<input type="checkbox"/>	<input type="checkbox"/>
17) Have you had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>
18) Do you have any skin problems (rash, acne, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
19) Is there a history of bed wetting?	<input type="checkbox"/>	<input type="checkbox"/>
20) Is an orthodontic appliance being brought to camp?	<input type="checkbox"/>	<input type="checkbox"/>
21) Do you wear glasses, contacts or protective eye wear (other than squash goggles)?	<input type="checkbox"/>	<input type="checkbox"/>
*If you answered yes to any of the above, please provide details on another page.		

ATTENTION PARENT:

Please attach copy of camper's health insurance card to this form

MEDICAL FORM

PHYSICIAN SECTION

Camper Name _____

* Please complete the questions below. Use additional sheets as necessary.

1. I have reviewed this entire medical form and confirm that all information herein and on any attached pages is correct.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. The above person is able to participate in an active camping program.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3. The applicant is under the care of a physician for the following conditions:		
Current Treatment includes:		
4. Recommendations and restrictions at camp:		
5. Treatment to be continued at camp:		
6. Medications to be administered at camp (see attached sheet):		
7. Any medically prescribed meal dietary restrictions:		
8. Any allergies to be noted:		

Physical exam					
Last Examination:		Date:			
Height		Weight		BP	
Immunization history					
Vaccine up to date				Yes	No
Measles		<input type="checkbox"/>	<input type="checkbox"/>		
Mumps		<input type="checkbox"/>	<input type="checkbox"/>		
Rubella		<input type="checkbox"/>	<input type="checkbox"/>		
Chickenpox		<input type="checkbox"/>	<input type="checkbox"/>		
Tetanus *	Date:	<input type="checkbox"/>	<input type="checkbox"/>		
Hepatitis B		<input type="checkbox"/>	<input type="checkbox"/>		
Diphtheria		<input type="checkbox"/>	<input type="checkbox"/>		
Pertussis		<input type="checkbox"/>	<input type="checkbox"/>		
Polio		<input type="checkbox"/>	<input type="checkbox"/>		
* Date of last tetanus shot is required					

Physician's Signature		Date		Printed Name	
Address					
Phone		Form completed by		Date completed	

NON-PRESCRIPTION AUTHORIZATION

Parent & Physician must initial each approved non-prescription medication & write full signature on page 2

Camper Name _____ Age _____ Weight _____

Acetaminophen		tablets (i.e. Tylenol Regular Strength) 325 mg. ea. elixir (80 mg. per 1/2 tsp)	
Purpose:	pain reliever/fever reducer		
Dosage:	<110 lbs...1 tablets every 4-6 hours as needed; not to exceed 4 tablets in a 24 hour period >110 lbs...2 tablets every 4-6 hours as needed; not to exceed 8 tablets in a 24 hour period or Elixir ...60-71 lbs: 2 1/2 tsp...; 72-95 lbs: 3 tsp...every 4 hours as needed; not to exceed 5 doses in 24 hour period		
Parent's Initials			Physician's Initials

Ibuprofen		tablets (i.e. Advil) 200 mg. ea. oral suspension (i.e. Children's Advil) 100 mg. per tsp.	
Purpose:	pain reliever/fever reducer		
Dosage:	<110 lbs...1 tablet every 4-6 hrs.; not to exceed 4 tablets in 24 hr. pd. >110 lbs...2 tablets every 4-6 hrs; not to exceed 4 tablets in 24 hr. pd. for children 60-71 lbs: 2 1/2 tsp...72-95 lbs: 3tsp...every 6-8 hours as needed but no more than 4x a day		
Parent's Initials			Physician's Initials

Guaifenesin		syrup (i.e. Robitussin) 100 mg. per tsp.	
Purpose:	loosens & relieves chest congestion		
Dosage:	<110 lbs... 1 1/2 tsp every 4 hours >110 lbs... 3 tsp every 4 hours		
Parent's Initials			Physician's Initials

Pepto-Bismol		chewable tablets or liquid	
Purpose:	relief for upset stomach, indigestion, nausea, heartburn, diarrhea		
Dosage:	<110 lbs... 1 tablet (or 1 tbsp) every 1/2 to 1 hour as needed; max of 8 doses in 24 hr. pd. >110 lbs... 2 tablets (or 2 tbsp) every 1/2 to 1 hour as needed; max of 8 doses in 24 hr. pd.		
Parent's Initials			Physician's Initials

Mylanta		liquid	
Purpose:	antacid-anti-gas		
Dosage:	>110 lbs...shake well, take 3 tsps. between meals; not to exceed 24 tsps. in 24 hr. pd.		
Parent's Initials			Physician's Initials

Dramamine		chewable tablets 50 mg. ea.	
Purpose:	motion sickness		
Dosage:	<110 lbs...1 tablet every 6-8 hours, not to exceed 3 tablets in 24 hr. pd. >110 lbs...2 tablets every 4-6 hours, not to exceed 8 tablets in 24 hr. pd.		
Parent's Initials			Physician's Initials

NON-PRESCRIPTION AUTHORIZATION

Camper Name _____ Age _____ Weight _____

Pseudoephedrine HCL		tablets (i.e. Dimetapp) 120 mg. ea.	
Purpose:	relieves nasal & sinus congestion due to colds & allergies		
Dosage:	>110 lbs...1 caplet every 12 hours not to exceed 2 caplets in 24 hrs.		
Parent's Initials		Physician's Initials	

Diphenhydramine HCL		(i.e. Benadryl) tablets 25 mg. ea.; liquid 12.5 mg. per tsp.	
Purpose:	relief from allergic reactions i.e. stuffy, runny nose, sneezing, itchy, watery eyes, itchy throat		
Dosage:	<110 lbs...1 tsp. every 4-6 hrs.; do not take more than 6 doses in 24 hr. pd. >110 lbs...2 tsp liquid or 1 tablet every 4-6 hrs.; do not exceed 6 tablets (6 doses) in 24 hr. pd.		
Parent's Initials		Physician's Initials	

Immodium		caplets (each contains 2 mg loperamide HCL)	
Purpose:	diarrhea		
Dosage:	<110 lbs...1 caplet after the first loose stool; 1/2 caplet after each subsequent loose stool; no more than 3 caplets in 24 hours >110 lbs...2 caplets after the first loose stool; 1 caplet after each subsequent loose stool; no more than 4 caplets in 24		
Parent's Initials		Physician's Initials	

Bacitracin Ointment			
Purpose:	prevention of infection in minor cuts, scrapes, burns		
Dosage:	apply small amount to affected area 1-3x daily		
Parent's Initials		Physician's Initials	

Caladryl Lotion			
Purpose:	relief from poison ivy		
Dosage:	shake well; wash affected area; apply no more than 3-4x daily		
Parent's Initials		Physician's Initials	

Hydrocortisone cream 1%			
Purpose:	relief of itching from minor skin irritations, inflammation & rashes		
Dosage:	apply to affected area no more than 3-4x daily		
Parent's Initials		Physician's Initials	

Parent & Physician full signature:

PARENT SIGNATURE _____

Date _____

PHYSICIAN SIGNATURE _____

Date _____

PRESCRIBED MEDICATION AUTHORIZATION Part 1

Part 1 must be signed by physician and part 2 must be signed by parent

AUTHORIZATION BY PHYSICIAN

Camper Name		Date of Birth	
Address			
Condition for which drug is being administered during camp hours:			
DRUG: Name of Drug, Dose and Method of Administration			
Times of Administration:	__ : __ m, __ : __ m, __ : __ m		
Medication shall be administered from	__ / __ / __ - __ / __ / __		
Relevant side effects to be observed, if any			
If there are side effects, plan for management			
Is this a controlled drug?			
Allergies, reaction to, or negative interaction with food or drugs? If YES, list			
The authorized prescriber's (Doctor) or Dentist's Name		Phone	
Address			

PHYSICIAN SIGNATURE



Date

PRINTED NAME

PREScribed MEDICATION AUTHORIZATION Part 2

AUTHORIZATION BY PARENT for the administration of the medication detailed in above Part 1:

I hereby request that the above medication, ordered by the authorized prescriber / dentist for my child, _____ be administered by the nurse or by camp personnel with current Medication Administration Training.

I understand that I must supply the Youth Camp with the prescribed medication in the original container dispensed and properly labeled by an authorized prescriber, dentist or pharmacist. Over the counter medications shall be in the original container labeled by the parent with the child's name. I understand that this medication will be destroyed if it is not picked up within one (1) week following termination of the order.

**PARENT
SIGNATURE**

A large yellow rectangular box redacting the parent's signature.

Date

**PRINTED
NAME**

**RELATIONSHIP
TO CHILD**

CONFIDENTIAL INFORMATION FORM & DISCLOSURE STATEMENT

A special note regarding this form

Since children often automatically use their behavior rather than their words to tell us what is bothering them, having advance knowledge of areas that might be difficult for your child really helps us understand the message in his or her actions so we can assure him or her of the best possible summer camp experience.

Information such as a learning difficulty or a recent loss in or out of the family or a major change in the family or in the child's life can be the crucial factor in helping us be sensitive to your child's need for patience, understanding and reassurance.

Our commitment is never to misuse such information or to release it to unauthorized persons. It will never be used at camp unless necessary and then only with the greatest of discretion. If you wish, we will inform you of any need to share this information with the staff who are most in contact with your child and will certainly let you know if your child is having difficulty. If you have any special concerns about this information or about your child, please feel free to call or write us. As a team we can better assure your child of a successful time at camp.

Camper Name		Grade (Beginning Sep-20)	
Frist Time Camper	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

Allergies and/or medical problems (just list them here and we will check the medical form for the details):

Any information you can furnish us with, regarding your child's personality traits, relationships with peers and adults, fears, etc. would be most helpful in assuring him/her a happy and productive summer (use other side as necessary):

DISCLOSURE STATEMENT: By signing below, the parent guarantees full disclosure of important camper issues in space provided above.

**PARENT
SIGNATURE**

Date _____

BEHAVIOR CONTRACT

When campers are respectful of the environment & one another the INTENSITY camp 'experience' can be amazing.

Our campers must understand that they are accountable for their actions and to accept the consequences of inappropriate behaviors.

Below are some examples where parents may be called or campers may even be sent home without refund:

- Misbehavior and bullying which includes but is not limited to: hitting, punching, threatening, aggressive behavior, verbal abuse, teasing, excluding, name calling, pranking, hazing or making racial / ethnic slurs
- Inappropriate sexual behavior
- Sleeping through meals or activities
- Being in the dorm rooms during activity periods or meals
- Stealing, destroying camp or camper property
- Sneaking out of dorm after curfew... camper is sent home the next day
- Possession of cigarettes, e-cigarettes, illegal drugs or alcohol, matches, weapons, etc.
- General disrespect of campers, staff or the environment

These are just examples & not the only reasons that parents may be called or campers may be sent home without refund.

We require that both parent and camper sign and return this to us before camp.

The undersigned understand the above contract & agree to be bound by the same.

Parent & Camper Signature:

CAMPER
SIGNATURE

Date

PARENT
SIGNATURE

Date
