The Barn Summer Day Camp
Health Exam/Record

Physical Exams are Valid for 3 Years
From Date of Last Examination

Please Return Completed Form to the Camp

Name _____Date of Birth _____
Address _____
Emergency Contact_____ Phone_____
Relationship to Camper _____ Alternate Phone _____
……

TO BE COMPLETED BY THE SPECIFIED MEDICAL PARCTITIONER

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 medication(s)? □ YES □ NO If yes, indicate names of Medication(s):_____
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 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
Measles			Pertussis		
Hepatitis			Chickenpox		
Mumps			Polio		
Diphtheria			Tetanus		
Rubella					

Comments:_____
_____

Print name of medical care provider:_____
Medical care provider's address: _____
Medical care provider's: City/Town_____ State____ Zip Code_____

_____
Signature of Physician, PA, APRN,RN

_____
Date form signed

_____
Telephone Number

Authorization for the Self-Administration of Medication While Attending Programs at the Madison Arts Barn

Parent/guardians requesting to be self-administered by their child while at camp shall provide the program with appropriate written authorization and the medication before any medications are administered. Medications must be in the original container and labeled with child's name, name or medication, directions for medication's administration and date of the prescription. All unused medication will 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 Self-Administration

Medication Administration: Start Date ___/___/___ Stop Date ___/___/___

Relevant Side Effects of Medication _____

Plan of Management for Side Effects _____

Known Food or Drug: Allergies? ☐Yes ☐No Reactions to? ☐Yes ☐No NO interactions with? ☐Yes ☐No

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

Prescriber's Name _____ Phone Number _____ _____

Prescriber's Address _____ Town _____ ST _____

Prescriber's Signature _____

Parent/Guardian Authorization:

I request that medication be self-administered by my child as described and directed above.

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

Child's Name _____ Address _____ Town _____

Name of Parent/Guardian Authorizing Self-Administration of Medication_____

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

Address _____ Town _____ Phone # _____ _____

Signature of Parent/Guardian Authorizing Self-Administration of Medication_____

Name of Camp Personnel Receiving Written Authorization and Medication _____

Title/Position _____ Signature (in ink) _____