

**Regional YMCA of Western Connecticut  
Greenknoll Day Camp  
2 Huckleberry Hill Road  
Brookfield, CT 06804**

**Before June 13, 2008  
Phone: (203) 775-4444  
Fax: (203) 740-9289**

**After June 13, 2008  
Phone: (203) 775-9363  
Fax: (203) 740-3639**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Phone \_\_\_\_\_

Parent(s)/Guardian(s) \_\_\_\_\_

\_\_\_\_\_ Address \_\_\_\_\_

**TO BE COMPLETED BY A MEDICAL PRACTITIONER:  
A physician must have completed a physical examination within the last 36 months.**

\_\_\_\_\_ May participate in all camp activities

\_\_\_\_\_ May participate except for:

<b>Date of Exam</b> _____
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Medical information pertinent to routine care and emergencies: \_\_\_\_\_

Is this individual taking prescription medication?     YES     NO

If yes, indicate prescription: \_\_\_\_\_

Does the individual have allergies?     YES     NO    Explain: \_\_\_\_\_

Is the individual on a special diet?     YES     NO    Explain: \_\_\_\_\_

This camper/staff 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:

	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>
Measles			Hepatitis B		
Mumps			Diphtheria		
Rubella			Pertussis		
Chickenpox			Polio		
Tetanus					

Comments: \_\_\_\_\_

Print name of medical care provider: \_\_\_\_\_

Medical care provider's address: \_\_\_\_\_

Medical care provider's: City/Town \_\_\_\_\_ ST \_\_\_\_\_ Zip Code \_\_\_\_\_

\_\_\_\_\_  
Signature of Physician, APRN or PA

\_\_\_\_\_  
Date Form Signed

\_\_\_\_\_  
Telephone Number

**AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATIONS  
BY GREENKNOLL DAY CAMP PERSONNEL**

The Connecticut State Law and Regulations require a physician's or dentist's written order and parent or guardian's authorization for a nurse, first aider, the director or alternate director to administer medications. Prescription medications must be in pharmacy prepared containers and labeled with the name of the child, name of the drug, strength, dosage, frequency, physician's or dentist's name and date of the original prescription. Over the counter medication must be in the original container and labeled with the child's name.

PHYSICIAN OR DENTIST'S ORDER: Date \_\_\_/\_\_\_/\_\_\_

Name of Child: \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_

Street Address \_\_\_\_\_

City/Town \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Condition for which drug is being administered during camp hours: \_\_\_\_\_

DRUG: Name of Drug, Dose and Method of Administration \_\_\_\_\_

Times of Administration: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

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 to food or drugs? \_\_\_\_\_ If YES, list \_\_\_\_\_

Physician's/Dentist's Name \_\_\_\_\_ Phone # \_\_\_\_\_  
(Type or Print)

Street Address \_\_\_\_\_

City/Town \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Physician or Dentist's Signature \_\_\_\_\_

**PARENT AUTHORIZATION:**

Date: \_\_\_/\_\_\_/\_\_\_

To nurse, first aider, director, alternate director or youth camp counselor:

I hereby request that the above medication, ordered by the physician/dentist for my child \_\_\_\_\_, be administered by the nurse, first aider, director, alternate director or youth camp counselor.

I understand that I must supply the Youth Camp with the prescribed medication in the original container dispensed and properly labeled by a physician or pharmacist. Over the counter medication 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.

Name of Parent or Guardian \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
(Print Name)

Signature \_\_\_\_\_ Date \_\_\_\_\_ Phone \_\_\_\_\_

Street Address \_\_\_\_\_ City/Town \_\_\_\_\_ State \_\_\_\_\_