DISCOVERY ADVENTURES P.O. BOX 31 GLOUCESTER, MA 01930 (978) 283-3320

DISCOVERY ADVENTURES SUMMER CAMP PROGRAM

REGISTRATION & HEALTH HISTORY

Child's Name _____Age ___Ht___Wt___ Sex:M ☐ F ☐

Name of Parent or Guardian _____

Home Address _____

Phone (home) _____(work) _____(cell)_____

Email Address_____

Emergency Contact _____ Phone _____

HEALTH HISTORY OF CHILD (check – give approx. dates if applicable)

☐ Frequent Ear Infections	☐ Penicillin	☐ Chicken Pox
☐ Heart Defect/Disease	☐ Asthma	☐ Mumps
☐ Hay Fever	☐ Other drugs	☐ Measles
☐ Seizures	☐ Hypertension	☐ German Measles
☐ Insect Sting	☐ Poison Ivy, Oak, Sumac	☐ Bleeding/Clotting Disorders
☐ Diabetes	☐ Mononucleosis	☐ Other

Allergies: NO YES If yes, please specify:_____

Foods: NO YES If yes, please specify:_____

Recent Surgeries or Serious Injuries (dates): _____

Chronic/Recurring Injuries/Illnesses: _____

Current Medications? NO **YES Medication type:_____

For what condition/illness is medication used? _____

***__If you checked "YES" for medications, please complete our Medication Authorization Form__

The Discovery Adventures Program is equipped with first aid kits that include the following over-the-counter medications which are approved by our consulting physician. All staff members are First Aid and CPR certified and present during camp hours. In the event of illness or injury, these medications are available for administration by staff members only. All medications are current, stored in water-proof containers, checked weekly and re-supplied or replaced when necessary. Please check and initial to approve the use of:

☐ Ibuprofen ☐ Non-Aspirin (Tylenol) ☐ Diphenhydramine (Benadryl, antihistamine) ☐ Pepto-Bismol ☐ Dramamine (non-drowsy, for motion sickness) ☐ Anti-diareal

Name of Family Physician _____ Phone_____

Name of Dentist/Orthodontist_____ Phone _____

Insurance Provider & Plan # _____

Authorization for Treatment: I hereby give permission to the medical personnel selected by the program director to administer treatment and/or authorized medications and arrange necessary related transportation for my child in the event of an illness or injury. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the program director to secure and administer treatment, including hospitalization, for the person named above.

Signature of Parent/Guardian _____Date _____

DISCOVERY ADVENTURES P.O. BOX 31 GLOUCESTER, MA 01930 (978)283-3320

DISCOVERY ADVENTURES SUMMER PROGRAM

HEALTH & IMMUNIZATION HISTORY

In accordance with Massachusetts Department of Public Health regulations, no child may attend camp without completed immunization/health forms on site. Your failure to submit this form will cause your child to be excused from camp. No refunds will be given.

TO BE FILLED OUT BY PHYSICIAN

Child's Name: _____ Birthdate: ____/____/____ Sex: _____

HEALTH CARE RECOMMENDATIONS BY LICENSED PHYSICIAN

I have examined the above applicant within the past two years. Date examined: _____

In my opinion, the camper's condition does ☐ does not ☐ preclude his/her participation in a day camp program.

Height _____ Weight _____ Blood Pressure _____

The applicant is under the care of a physician for the following condition: _____

_____

_____

Current Treatment (Include current medications): _____

_____

Explanation of any related loss of consciousness, seizure activity or concussion: _____

_____

Does applicant have epilepsy? No ☐ Yes ☐ Diabetes? No ☐ Yes ☐

RECOMMENDATIONS AND RESTRICTIONS FOR CHILD: _____

_____

_____

IMMUNIZATION HISTORY

VACCINE	DATE	VACCINE	DATE
Hepititis B	1. _____ 2. _____ 3. _____	**Hib**	1. _____ 2. _____ 3. _____ 4. _____
DtaP DTP DT TD	1. _____ 2. _____ 3. _____ 4. _____ 5. _____	**MMR**	1. _____ 2. _____
		Varicella	1. _____ 2. _____
IPV OVP	1. _____ 2. _____ 3. _____ 4. _____	**Chickenpox History** ☐ Check here if this person has a history of chickenpox.	

Other _____

_____

Licensed Physician Signature: _____

Address: _____

Phone: _____

Date of Form Completion _____ ***By** _____

(initial if completed by nurse or physician's assistant)

DISCOVERY ADVENTURES P.O. BOX 31 GLOUCESTER, MA 01930 (978)283-3320

DISCOVERY ADVENTURES SUMMER PROGRAM

MEDICATION AUTHORIZATION FORM

IF YOUR CHILD WILL BE NEEDING MEDICATION DURING CAMP SESSIONS, PLEASE COMPLETE THE FOLLOWING:

105 CMR 430.160(A) *Medication prescribed for campers 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 campers shall be kept in the original containers containing the original label, which shall include the directions for use. Medications will be stored in locked containers.*

105 CMR 430.160(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 or medications shall be under the professional oversight of the health care consultant. Medication prescribed for campers brought from home shall only be administered if it is from the original container, there is written permission from the parent/guardian and the health care consultant approves in writing the administration of the medication.*

105 CMR 430.160(D) *When no longer needed, medications shall be returned to a parent/guardian whenever possible. If the medication cannot be returned, it shall be destroyed.*

*Health Supervisor – A person who is at least 18 yrs. of age, specially trained and certified in first aid as well as current American Heart Association CPR, has been trained in the administration of medications and is under the professional oversight of a licensed health care professional authorized to administer prescription medications.

Name of Camper: _____ **Age:** _____

Parent or Guardian Name: _____

Name of Licensed Prescriber: _____

Name of Prescribed Medication(s): _____

Dosage information: _____

Route of Administration: _____

Expiration Date of Medications Received: _____

Special Storage Requirements: _____

Specific Directions (e.g., on empty stomach/with water, etc.): _____

_____

Specific Precautions: _____

Possible Side Effects/Contraindications: _____

Other medications (at parent's discretion): _____

I hereby authorize Discovery Adventures to administer to my child the medications specified above:

Parent/Guardian Signature: _____ **Date:** _____

Health Consultant Signature: _____ **Date:** _____
(Discovery Adventures staff)