DIScover Summer Camp
Camper Form Packet
2018

Completed forms due to Anthony Carter, Danvers Indoor Sports by June 8th OR One week prior to camp attendance. Email to Anthony@danversindoorsports.com

DIScover Summer Camp Personal History Form

Please submit this form before **June 8th, 2018** along with the other necessary forms. All information provided is kept strictly confidential. The main purpose is to aid the staff and (if necessary) emergency personnel to better help your child.

Name: _____ Nickname: _____Date of Birth:_____

Does DOB occur during camp week? Y N In the fall, the camper will enter grade _____

Names of brothers/sisters _____

Name of parent/legal guardian 1 _____

Address:_____ Home phone:_____ Cell phone:_____

Name of parent/legal guardian 2 _____

Address:_____ Home phone:_____ Cell phone:_____

Parents' Marital Status _____

Please list any physical or behavioral conditions that your camper's counselors should be aware of, with activity restrictions and management plan: (This information is very important to counselors; attach separate sheet if necessary.)

_____

_____

Please list any camper allergies or dietary restrictions:_____

Has your child attended a day camp before? If so, please list most current:

_____

List camper's interests and hobbies and school activities: _____

_____

List three goals for your camper while at camp:

1)_____

2)_____

3)_____

Are there any activities that you do not want your camper to participate? If so, please list here: _____

DIScover Summer Camp Permission Slips

Please check the blanks for all the below statements, then sign and date.

Permission Slip for HEAD LICE CHECK

I do _____ do not _____ give permission for my child's head to be checked for head lice.

Permission Slip for Snack

I do _____ do not _____ give permission for DIScover Summer Camp to provide my child with a **nut-free** snack if they do not have one.

Permission Slip for Photos/Videos

I do _____ do not ____ give permission for DIScover Summer Camp and Danvers Indoor Sports to use any photos or videos of my child while he/she is at camp to use for promotion and marketing purposes.

_____ _____

Parent Signature Date

EMERGENCY CARE FORM

** EMERGENCY CONTACT CANNOT BE PARENT 1 or 2 **

NAME OF CHILD_____DOB_____

ADDRESS_____

HOME PHONE_____

PARENT 1 NAME_____

DAY PHONE_____CELL PHONE_____

PARENT 2 NAME _____

DAY PHONE_____CELL PHONE_____

EMERGENCY CONTACT(1)_____RELATIONSHIP_____

PHONE_____

EMERGENCY CONTACT(2)_____RELATIONSHIP_____

PHONE_____

HEALTH INSURANCE COMPANY_____POLICY #:_____

PHYSICIAN & PHONE NUMBER_____

ALLERGIES _____

I understand that this release will only be used if I/we cannot be reached by the camp. I give permission to have my child_____, taken to the nearest physician or hospital in case of emergency and to have anesthesia administered if necessary and/or to have a qualified person administer first aid, if necessary.

_____ _____

Signature of parent/legal guardian **Date**

Parent Authorization Pickup Form

I, _____ give permission to_____ ,

(Parent name)

_____, _____ , _____

or _____to pick up my child,_____

(Child's name)

from DIScover Summer Camp.

Persons not included in this form do not have permission to pickup my child.

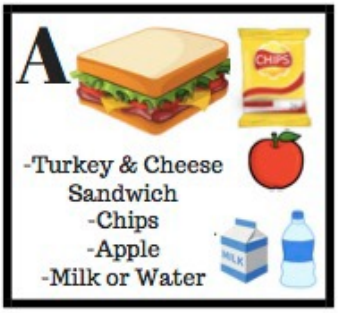
_____ _____

Parent Signature Date

Lunch Order Form

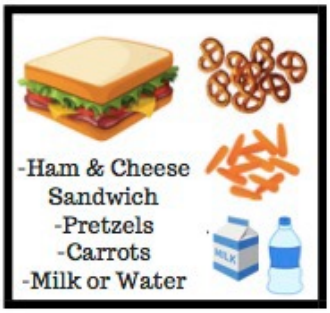
($6 Per Meal)

A



-Turkey & Cheese Sandwich
-Chips
-Apple
-Milk or Water

B



-Ham & Cheese Sandwich
-Pretzels
-Carrots
-Milk or Water

C

-Chicken Tenders
-Chips
-Watermelon
-Milk or Water

D

-Pizza
-Pretzels
-Orange
-Milk or Water

Participant Name: _____

Parent/ Guardian E-mail: _____

Parent/ Guardian Phone #: _____

Please circle A, B, C or D for lunch meal

Vegetarian or Gluten Free Option Available upon request

Week	Monday	Tuesday	Wednesday	Thursday	Friday	Total (# of meals x $6)
Pre - Week June 18 - June 22	A B C D	A B C D	A B C D	A B C D	A B C D	
Week 1 June 25 - June 29	A B C D	A B C D	A B C D	A B C D	A B C D	
Week 2 July 2-3, 5-6	A B C D	A B C D	A B C D	A B C D	A B C D	
Week 3 July 9 - July 13	A B C D	A B C D	A B C D	A B C D	A B C D	
Week 4 July 16 - July 20	A B C D	A B C D	A B C D	A B C D	A B C D	
Week 5 July 23 - July 27	A B C D	A B C D	A B C D	A B C D	A B C D	
Week 6 July 30 - August 3	A B C D	A B C D	A B C D	A B C D	A B C D	
Week 7 August 6 - August 10	A B C D	A B C D	A B C D	A B C D	A B C D	
Week 8 August 13 - August 17	A B C D	A B C D	A B C D	A B C D	A B C D	
Week 9 August 20 - August 24	A B C D	A B C D	A B C D	A B C D	A B C D	
Week 10 August 27 - August 31	A B C D	A B C D	A B C D	A B C D	A B C D	

Please Mail or Email Completed Menu by June 8th to Danvers Indoor Sports ATTN: Anthony Carter or Anthony@danversindoorsports.com

Massachusetts Department of Public Health

CERTIFICATE OF IMMUNIZATION

Name: _____

Date of Birth: / / **Sex:** ☐ **female** ☐ **male**

If combination vaccine is administered, please indicate vaccine type (e.g., DTaP-Hib, etc.)

Vaccine		Date/Vaccine Type	Vaccine		Date/Vaccine Type
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV)	1		***Haemophilus influenzae* type b** (e.g., Hib, HepB-Hib, DTaP-Hib)	1	
	2			2	
	3			3	
Diphtheria, Tetanus, Pertussis (e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td)	1			4	
	2		**Measles, Mumps, Rubella** (MMR)	1	
	3			2	
	4		**Varicella** (Var)	1	
	5			2	
	6		**Hepatitis A** (HepA)	1	
	7			2	
Polio (e.g., IPV, DTaP-HepB-IPV)	1		**Pneumococcal Polysaccharide** (PPV23)	1	
	2			2	
	3		**Influenza** Inactivated (Intramuscular) or Live (Intranasal)	1	
	4			2	
Pneumococcal Conjugate (PCV7)	1			3	
	2		**Other:**		
	3				
	4				

Serologic Proof of Immunity		Check One	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		
* Must also check Chickenpox History box.			

Chickenpox History

☐ Check the box if this person has a physician-certified reliable history of chickenpox.

Reliable history may be based on:

- physician interpretation of parent/guardian description of chickenpox
- physical diagnosis of chickenpox, or
- serologic proof of immunity

I certify that this immunization information was transferred from the above-named individual's medical records.

Doctor or nurse's name *(please print)* **Date:** / /

Signature: _____

Facility name: _____

Authorization to Administer Medication to a Camper

(completed by parent/guardian)

Camper and Parent/Guardian Information	
Camper's Name:	
Age:	Food/Drug Allergies:
Diagnosis(at parent/guardian discretion):	
Parent/Guardian's Name:	
Home Phone:	Business Phone:
Emergency Telephone:	

Licensed Prescriber Information	
Name of Licensed Prescriber:	
Business Phone:	Emergency Phone:

Medication Information 1	
Name of Medication:	
Dose given at camp:	Route of Administration:
Frequency:	Date Ordered:
Duration of Order:	Quantity Received:
Expiration date of Medication Received:	
Special Storage Requirements:	
Special Directions (e.g., on empty stomach/with water):	
Special Precautions:	
Possible Side Effects/Adverse Reactions:	
Other medications (at parent/guardian discretion):	
Location where medication administration will occur:	

Medication Information 2	
Name of Medication:	
Dose given at camp:	Route of Administration:
Frequency:	Date Ordered:
Duration of Order:	Quantity Received:
Expiration date of Medication Received:	
Special Storage Requirements:	
Special Directions (e.g., on empty stomach/with water):	
Special Precautions:	
Possible Side Effects/Adverse Reactions:	

Other medications (at parent/guardian discretion):

Location where medication administration will occur:

Authorization Information

I hereby authorize the health care consultant or properly trained health care supervisor at _____
(name of camp)
to administer, to my child, _____ the medication(s) listed above, in accordance with 105 CMR
(name of camper)
430.160(C) and 105 CMR 430.160(D) [see below].

If above listed medication includes epinephrine injection system:
I hereby authorize my child to self-administer , with approval of the health care consultan
t☐Yes ☐No☐Not Applicable

I hereby authorize an employee that has received training in allergy awareness and epinephrine administration to administer
☐Yes ☐No ☐ Not Applicable

If above listed medication includes insulin for diabetic management:
I hereby authorize my child to self-administer , with approval of the health care consultant
☐Yes ☐No ☐ Not Applicable

Signature of Parent/Guardian:	Date:

** **Health Care Consultant**at a recreational camp is a Massachusetts licensed physician, certified nurse practitioner, or a physician assistant with documented pediatric training. **Health Care Supervisor** is a staff person of a recreational camp for children who is 18 years old or older; is responsible for the day to day operation of the health program or component, and is a Massachusetts licensed physician, physician assistant, certified nurse practitioner, registered nurse, licensed practical nurse, or other person specially trained in first aid.

105 CMR 430 References

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. **(M.G.L. c. 94C § 21).**

105 CMR 430.160(C): Medication shall only be administered by the health care supervisor or by a licensed health care professional authorized to administer prescription medications. If the health care supervisor is not a licensed health care professional authorized to administer prescription medications, the administration of medications shall be under the professional oversight of the health care consultant. The health care consultant shall acknowledge in writing a list of all medications administered at the camp. Medication prescribed for campers brought from home shall only be administered if it is from the original container, and there is written permission from the parent/guardian.

105 CMR 430.160(D):A written policy for the administration of medications at the camp shall identify the individuals who will administer medications. This policy shall:
(1) List individuals at the camp authorized by scope of practice (such as licensed nurses) to administer medications; and/or other individuals qualified as health care supervisors who are properly trained or instructed, and designated to administer oral or topical medications by the health care consultant.
(2) Require health care supervisors designated to administer prescription medications to be trained or instructed by the health care consultant to administer oral or topical medications.
(3) Document the circumstances in which a camper, Heath Care Supervisor, or Other Employee may administer epinephrine injections. A camper prescribed an epinephrine auto-injector for a known allergy or pre-existing medical condition may:
a) Self-administer and carry an epinephrine auto-injector with him or her at all times for the purposes of self-administration if:
1) the camper is capable of self-administration; and
2) the health care consultant and camper's parent/guardian have given written approval
(b) Receive an epinephrine auto-injection by someone other than the Health Care Consultant or person who may give injections within their scope of practice if:
1) the health care consultant and camper's parent/guardian have given written approval; and
2) the health care supervisor or employee has completed a training developed by the camp's health care consultant in accordance with the requirements in 105 CMR 430.160.
(4) Document the circumstances in which a camper may self-administer insulin injections. If a diabetic child requires his or her blood sugar be monitored, or requires insulin injections, and the parent or guardian and the camp health care consultant give written approval, the camper, who is capable, may be allowed to self-monitor and/or self-inject himself or herself. Blood monitoring activities such as insulin pump calibration, etc. and self-injection must take place in the presence of the properly trained health care supervisor who may support the child's process of self-administration.

105 CMR 430.160(F): The camp shall dispose of any hypodermic needles and syringes or any other medical waste in accordance with 105 CMR 480.000: Minimum Requirements for the Management of Medical or Biological Waste.

105 CMR 430.160(I): When no longer needed, medications shall be returned to a parent or guardian whenever possible. If the medication cannot be returned, it shall be disposed of as follows:
(1) Prescription medication shall be properly disposed of in accordance with state and federal laws and such disposal shall be documented in writing in a medication disposal log.
(2) The medication disposal log shall be maintained for at least three years following the date of the last entry.

MASSACHUSETTS SCHOOL HEALTH RECORD

Health Care Provider's Examination

Name _____ ☐ Male ☐ Female Date of Birth:_____

Medical History _____

_____

Pertinent Family History

Current Health Issues

Y	N	
☐	☐	Allergies: Please list: Medications _____ Food _____ Other _____
		History of Anaphylaxis to _____ Epi -Pen®: ☐ Yes ☐ No
☐	☐	Asthma: Asthma Action Plan ☐ Yes ☐ No (*Please attach*)
☐	☐	Diabetes: ☐ Type I ☐ Type II
☐	☐	Seizure disorder: _____
☐	☐	Other (*Please specify*) _____

Current Medications (if relevant to the student's health and safety) *Please circle those administered in school; a separate medication order form is needed for each medication administered in school.*

Physical Examination **Date of Examination:**_____

Hgt: _____(_____%) Wgt:_____(_____%) BMI: _____(_____%) BP: _____

(Check = Normal / If abnormal, please describe.)

☐ General _____	☐ Lungs _____	☐ Extremities _____
☐ Skin _____	☐ Heart _____	☐ Neurologic _____
☐ HEENT _____	☐ Abdomen _____	☐ Other _____
☐ Dental/Oral _____	☐ Genitalia _____	

Screening:

	(Pass)	(Fail)
Vision: Right Eye	☐	☐
Left Eye	☐	☐
Stereopsis	☐	☐
Hearing: Right Ear	☐	☐
Left Ear	☐	☐
Postural Screening: (Scoliosis/Kyphosis/Lordosis)	☐	☐

Laboratory Results: ☐ Lead _____ Date _____ ☐ Other_____

The entire examination was normal: ☐

Targeted TB Skin Testing: ☐ Med-to-High risk (exposure to TB; born, lived, travel to TB endemic countries; medical risk factors):
TB Test Type: ☐ TST ☐ IGRA Date: _____ Result: ☐Positive ☐Negative ☐Indeterminate/Borderline
Referred for evaluation to: _____ Date:_____ ☐ Low risk (no TB test done)

This student has the following problems that may impact his/her educational experience:

☐ Vision ☐ Hearing ☐ Speech/Language ☐ Fine/Gross Motor Deficit
☐ Emotional/Social ☐ Behavior ☐ Other

Comments/Recommendations:_____

☐Y ☐N **This student may participate fully in the school program, including physical education and competitive sports. If no, please list restrictions:**_____

☐ Y ☐ N **Immunizations are complete: If no, give reason: Please attach Massachusetts Immunization Information System Certificate or other complete immunization record .**

_____ _____

Signature of Examiner *Circle:* MD, DO, NP, PA Date *Please print name of Examiner.*

_____

Group Practice Telephone

_____

Address City State Zip Code