

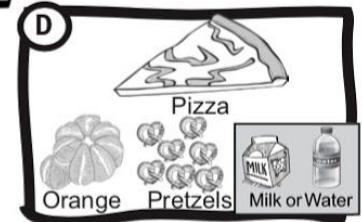
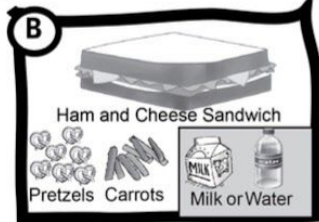
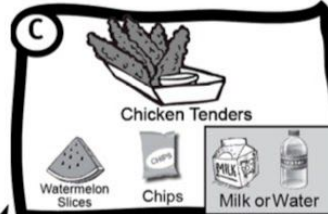
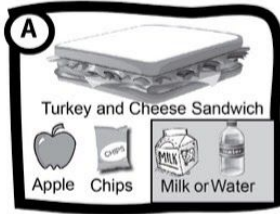


2019
DIScover Summer Camp
Camper Form Packet

Signature of parent/legal guardian

Date

Participant Name:
 Parent/Guardian E-mail:
 Parent/Guardian Phone Number:



*Vegetarian and Gluten Free options available. Please e-mail discover@danversindoorsports.com with request.

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

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
PreWeek June 17 - June 21 Too Cool For School	A B C D	A B C D	A B C D	A B C D	A B C D
Week 1 June 24 - June 28 DIS Olympics	A B C D	A B C D	A B C D	A B C D	A B C D
Week 2 July 1-3, 5 (No Camp July 4th) Star Spangled Banner	A B C D	A B C D	A B C D	A B C D	A B C D
Week 3 July 8 - July 12 DIS Movie Festival	A B C D	A B C D	A B C D	A B C D	A B C D
Week 4 July 15 - July 19 New England Sports Week	A B C D	A B C D	A B C D	A B C D	A B C D
Week 5 July 22 - July 26 Super Hero Week	A B C D	A B C D	A B C D	A B C D	A B C D
Week 6 July 29 - August 2 Worldwide Safari	A B C D	A B C D	A B C D	A B C D	A B C D
Week 7 August 5 - August 9 Harry Potters House Cup	A B C D	A B C D	A B C D	A B C D	A B C D
Week 8 August 12 - August 16 Cartoon Crazy	A B C D	A B C D	A B C D	A B C D	A B C D
Week 9 August 19 - August 23 Battle for Beantown	A B C D	A B C D	A B C D	A B C D	A B C D
Week 10 August 26 - August 30 Cold Wars	A B C D	A B C D	A B C D	A B C D	A B C D

(# meals x \$6=) (# meals x \$6=) (# meals x \$6=) (# meals x \$6=) (# meals x \$6=)

Please mail or email the completed menu by June 5 to:
 Danvers Indoor Sports attention: Anthony Carter OR Anthony@danversindoorsports.com

AUTHORIZATION TO ADMINISTER MEDICATION TO A CAMPER

(To be completed by parent/guardian)

Name of Camper: _____ Age: _____
Food/Drug Allergies: _____
Diagnosis (at parents discretion): _____

Parent/Guardian Name: _____
Home Telephone: _____
Business Telephone: _____
Emergency Telephone: _____

Name of Licensed Prescriber: _____

Business Telephone: _____
Emergency Telephone: _____

Name of Medication: _____ Dose given at camp: _____ Route of Administration: _____
Frequency: _____ Date Ordered: _____ Duration of Order: _____ Quantity Received: _____
Expiration date of Medications Received: _____ Special Storage Requirements: _____

Specific Directions (e.g., on empty stomach/with water): _____
Specific Precautions: _____
Possible Side Effects/Adverse Reactions: _____
Other medications (at parents' discretion): _____
Location where medication administration will occur: _____

I hereby authorize _____ to administer, to my child, _____ the medication(s)
(NAME OF CAMP) (NAME OF CHILD)
listed above, in accordance with 105 CMR 430.160.

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.

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. The health care consultant shall acknowledge in writing the list of medications administered at the camp. If the health 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. 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)

When no longer needed, medications shall be returned to a parent of guardian whenever possible. If the medication cannot be returned, it shall be destroyed.

*Health Supervisor – A person who is at least 18 years of age, specially trained and certified in at least current American Red Cross First Aid (or its equivalent) and 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.

Parent/Guardian Signature: _____ Date: _____

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
	4		
Diphtheria, Tetanus, Pertussis (e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td)	1	Measles, Mumps, Rubella (MMR)	1
	2		2
	3	Varicella (Var)	1
	4		2
	5		
	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	Other:	3
	2		
	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
<input type="checkbox"/> Check the box if this person has a physician-certified reliable history of chickenpox. Reliable history may be based on: <ul style="list-style-type: none"> • 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: _____

