2020
DIScover Summer Camp
Camper Form Packet

DIScover Summer Camp Personal History Form

D`YUgY gi Va]h h\]g Zcfa VYZcfY **June 4th, 2019** U cb[k]h\ h\Y ch\Yf bYWYggUfm Zcfa g" 5``]bZcfa Uh]cb dfcj]XYX]g _Ydh gh f]Wh m Wcb Z]XYbh]U " H\Y a U]b di fdcgY]g hc U]X h\Y ghUZZ UbX fl ZbYWYggUfmL Ya Yf[YbWm dYfgcbbY` hc VYhhYf \Y d mci f W]`X"

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DIScover Summer Camp Permission Slips

D`YUgY W\YW_ h\Y V`Ub_g Zcf U`` h\Y VY`ck gHUhYa Ybhgž h\Yb g][b UbX XUhY".

Permission Slip for HEAD LICE CHECK

=Xc SSSS Xc bch SSSS [ ]j Y dYfa]gg]cb Zcf a mW\]`X Eg \YUX hc VY W\YW_YX Zcf \YUX `]WY".

Permission Slip for Snack

=Xc SSSS Xc bch SSSS [ ]j Y dYfa]gg]cb Zcf 8=GWcj Yf Gi a a Yf 7Ua d hc dfcj]XY a mW\]`X k]h\ U **nut-free** gbUW_]Z h\Ym Xc bch \Uj Y cbY".

Permission Slip for Photos/Videos

=Xc SSSS Xc bch SSS [ ]j Y dYfa]gg]cb Zcf 8=GWcj Yf Gi a a Yf 7Ua d UbX 8Ubj Yfg =bXccf Gdcfhg hc i gY Ubm d\chcg cf j]XYcg cZ a mW\]`X k \]`Y \Y#g\Y]g Uh WUa d hc i gY Zcf dfca ch]cb UbX a Uf_Yh]b[di fdcgYg".

SSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSS SSSSSSSSSSSSSS

DUfYbh G][bUhi fY 8UhY

EMERGENCY CARE FORM

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

B5A9 C: 7<=@8SSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSS8C6SSSSSSSSSSSSSSSSS

588F9GGSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSS

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85MD<CB9SSSSSSSSSSSSSSSSSSSSSSSSS79@@ D<CB9SSSSSSSSSSSSSSSSSSSSSSSSS

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EMERGENCY CONTACT(1)__________________RELATIONSHIP_____________________

PHONE____

EMERGENCY CONTACT(2)__________________RELATIONSHIP_____________________

PHONE____

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Signature of parent/legal guardian **Date**

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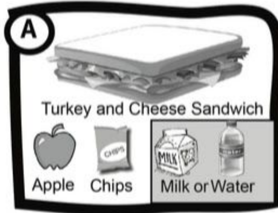
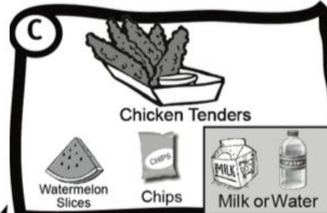
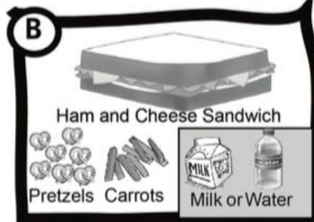
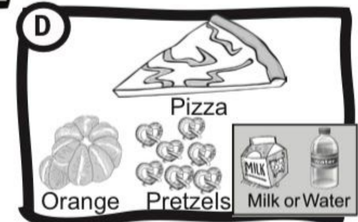
Participant Name:
Parent/Guardian E-mail:
Parent/Guardian Phone Number:

DISCOVER Summer Camp FITNESS. FUN. PLAY. DANVERS INDOOR SPORTS









*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 15 - June 19	A B C D	A B C D	A B C D	A B C D	A B C D
Week 1 June 22 - June 26	A B C D	A B C D	A B C D	A B C D	A B C D
Week 2 June 29 - July 3	A B C D	A B C D	A B C D	A B C D	A B C D
Week 3 July 6 - July 10	A B C D	A B C D	A B C D	A B C D	A B C D
Week 4 July 13 - July 17	A B C D	A B C D	A B C D	A B C D	A B C D
Week 5 July 20 - July 24	A B C D	A B C D	A B C D	A B C D	A B C D
Week 6 July 27 - July 31	A B C D	A B C D	A B C D	A B C D	A B C D
Week 7 August 3 - August 7	A B C D	A B C D	A B C D	A B C D	A B C D
Week 8 August 10 - August 14	A B C D	A B C D	A B C D	A B C D	A B C D
Week 9 August 17 - August 21	A B C D	A B C D	A B C D	A B C D	A B C D
Week 10 August 24 - August 28	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 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 ______________________________ (NAME OF CAMP) to administer, to my child, _________________________ (NAME OF CHIILD) the medication(s) 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	
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: