2020
DIScover Summer Camp
Camper Form Packet

ndoor Sports
sports.com

DIScover Summer Camp Personal History Form

Please submit this form before **June 4th, 2019** 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)

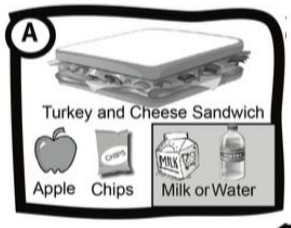
from DIScover Summer Camp.

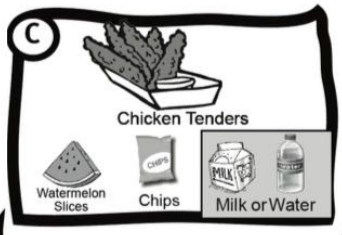
Persons not included in this form do not have permission to pickup my child.

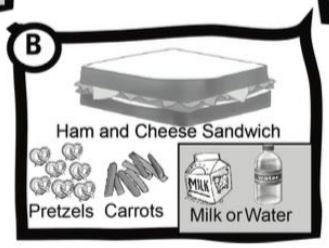
_____ _____

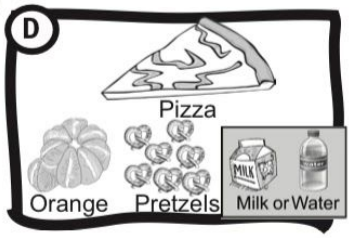
Parent Signature Date

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 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 _____ to administer, to my child, _____the medication(s)
(NAME OF CAMP) (NAME OF CHIILD)
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: _____

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