



**2022**

**DIScover Summer Camp  
Camper Form Packet**

# DIScover Summer Camp Personal History Form

Please submit this form before **June 1st, 2022** via emailing to [Anyhony@danversindoorsports.com](mailto:Anyhony@danversindoorsports.com) or mail it into 150R Andover Street, Danvers, MA 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.

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Parent Signature

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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

# AUTHORIZATION TO ADMINISTER MEDICATION TO A CAMPER

(To be completed by parent/guardian)

Name of Camper: \_\_\_\_\_ Age: \_\_\_\_\_ Parent/Guardian Name: \_\_\_\_\_

Food/Drug Allergies: \_\_\_\_\_ Home Telephone: \_\_\_\_\_

Diagnosis (at parents discretion): \_\_\_\_\_ 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	
<b>Hepatitis B</b> (e.g., HepB, HepB-Hib, DTaP-HepB-IPV)	1		<b>Haemophilus influenzae type b</b> (e.g., Hib, HepB-Hib, DTaP-Hib)	1		
	2			2		
	3			3		
		4				
<b>Diphtheria, Tetanus, Pertussis</b> (e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td)	1		<b>Measles, Mumps, Rubella</b> (MMR)	1		
	2			2		
	3		<b>Varicella</b> (Var)	1		
	4			2		
	5					
		6		<b>Hepatitis A</b> (HepA)	1	
		7			2	
<b>Polio</b> (e.g., IPV, DTaP-HepB-IPV)	1		<b>Pneumococcal Polysaccharide</b> (PPV23)	1		
	2			2		
	3		<b>Influenza</b> Inactivated (Intramuscular) or Live (Intranasal)	1		
	4			2		
<b>Pneumococcal Conjugate</b> (PCV7)	1		<b>Other:</b>	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"> <li>• physician interpretation of parent/guardian description of chickenpox</li> <li>• physical diagnosis of chickenpox, or</li> <li>• serologic proof of immunity</li> </ul>

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.)

<input type="checkbox"/> General _____	<input type="checkbox"/> Lungs _____	<input type="checkbox"/> Extremities _____
<input type="checkbox"/> Skin _____	<input type="checkbox"/> Heart _____	<input type="checkbox"/> Neurologic _____
<input type="checkbox"/> HEENT _____	<input type="checkbox"/> Abdomen _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Dental/Oral _____	<input type="checkbox"/> Genitalia _____	

### Screening:

	(Pass) (Fail)		(Pass) (Fail)		(Pass) (Fail)
Vision: Right Eye	<input type="checkbox"/> <input type="checkbox"/>	Hearing: Right Ear	<input type="checkbox"/> <input type="checkbox"/>	Postural Screening:	<input type="checkbox"/> <input type="checkbox"/>
Left Eye	<input type="checkbox"/> <input type="checkbox"/>	Left Ear	<input type="checkbox"/> <input type="checkbox"/>	(Scoliosis/Kyphosis/Lordosis)	
Stereopsis	<input type="checkbox"/> <input type="checkbox"/>				

**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:

<input type="checkbox"/> Vision	<input type="checkbox"/> Hearing	<input type="checkbox"/> Speech/Language	<input type="checkbox"/> Fine/Gross Motor Deficit
<input type="checkbox"/> Emotional/Social	<input type="checkbox"/> Behavior	<input type="checkbox"/> 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 \_\_\_\_\_