



2026

**DIScover Summer Camp
Camper Form Packet**

DIScover Summer Camp Personal History Form

Please submit this form before **June 5, 2026**, along with the other necessary forms. You can drop off at front office at DIS or mail to:

Danvers Indoor Sports

Attn: Faith Lee

150R Andover Street, Danvers, MA 01923

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. **Please print legibly in black pen. Please write legibly!**

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 a 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 in? 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 ****

PLEASE PRINT LEGIBLY!

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

PLEASE PRINT LEGIBLY IN BLACK PEN

I, _____ give permission to the following people listed below to pick up my child _____ (child's name) from DIScover Summer Camp.

<u>FIRST & LAST NAME</u>	<u>PHONE #</u>	<u>RELATIONSHIP TO CHILD</u>
(PARENT/GUARDIAN #1)		
(PARENT/GUARDIAN#2)		

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) listed above, in accordance with 105 CMR 430.160.
(NAME OF CAMP) (NAME OF CHILHD)

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: _____

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 _____