



2026 DIScover Summer Camp Camper Form Packet

Campers registered for the following summer camps must submit a completed packet, health record & immunizations:

- Multisport (full & half day, ages 5-12)
- Sport Specialty (Basketball, Lax, Football, ages 5-12)
 - CITs
- **JR'S MINI CLINIC (AGES 3.5-5) DOES NOT NEED TO FILL OUT PAPERWORK!**

If registering the night before 1st day of attending camp, then these documents must be submitted immediately to alexa@danversindoorsports.com.

This camp must comply with regulations of Massachusetts Department of Health & is licensed by the local Board of Health.

Please email this form at least 1 week before your child's first day of camp. If you're registering the night before their first day, then you must submit forms immediately to alexa@danversindoorsports.com or drop off at DIS front office.

First & Last Name: _____ Nickname: _____ Date of Birth: ____/____/____

Names of brothers/sisters: _____

Address: _____ City: _____ Zip: _____

Home phone: _____ Cell phone: _____

Email Address: _____

Name of parent/legal guardian #2 _____

Address: _____ City: _____ Zip: _____

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 (note: if bringing epipen, inhaler or medication to camp, you must complete “authorization to administer medication form”. See form below for more details:_____

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.

Permission Slip for SUNBLOCK

I do _____ do not _____ give permission for DIScover Summer Camp to apply SPRAY SUNBLOCK on my child. I am aware I must provide the sunblock in my camper's backpack and notify the camp director in the morning as a reminder to apply it.

Parent Signature

_____/_____/_____

Date

EMERGENCY CARE FORM

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

PLEASE PRINT LEGIBLY!

In the event of an emergency, parents will always be contacted first, as they have legal authority and primary responsibility for their child. The two non-parent emergency contacts are required as backup contacts in the event that parents cannot be reached during a serious emergency or if a child needs to be picked up due to illness and the parents are unavailable.

NAME OF CHILD _____ DOB ____/____/____

ADDRESS _____

PARENT #1 NAME _____

DAY PHONE _____ CELL PHONE _____

PARENT #2 NAME _____

DAY PHONE _____ CELL PHONE _____

EMERGENCY CONTACT(#3): _____ RELATIONSHIP _____

PHONE _____

EMERGENCY CONTACT(#4) _____ 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. I am aware that if someone other than those listed above is picking up my child, I will contact the Camp Director to notify them.

Parent Signature

_____/_____/_____

Date

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: _____

**ALL MEDICATION, INHALERS & EPIPENS MUST BE TURNED IN EACH MORNING TO
CAMP DIRECTOR FOR SAFEKEEPING AND EASY ACCESS IN CASE OF AN EMERGENCY.
IT WILL BE KEPT IN A LOCKED BOX THEN RETURNED AT DISMISSAL.**

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: _____

***For your convenience, you may attach your child's doctor-issued immunization record.**

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		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
☐ 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: _____

***For your convenience, you may attach your child's most recent physical examination record listing all of the information requested below.**

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 ☐ ☐

(Pass) (Fail)

Hearing: Right Ear ☐ ☐
Left Ear ☐ ☐

(Pass) (Fail)

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 _____

Please attach additional information as needed for the health and safety of the student.

MDPH 08/15/13