



If your child will be given medications while at Calumet, it would be helpful if you would include a small recent photo, for identification purposes.

The following are helpful guidelines for completing the Health Form. A \$50 fee will be charged for forms not completely filled out and returned to Calumet at least 4 weeks prior to arrival.

Please fill out form completely and then check these important places:

Page 1

- Completely filled out and emergency contacts listed
- Copy of Insurance Card attached

Page 3

- Signature required on bottom of page

Page 4

- Completed Health History, including allergies and restrictions

Page 5

- Completed "General Questions" and explained "yes" answers
- Completed immunizations or provided copy of immunizations
- Physician and Dentist/Orthodontist names and addresses listed

Page 6

- Date of Health Exam is within 2 years of attendance at camp
- Licensed Medical Personnel has listed medications to be administered at camp (this includes prescription medications as well as over-the-counter medications not listed on page 3.)
- Licensed Medical Personnel has signed and printed name
- Address and Phone numbers of Health Provider are listed

Page 7

- If needed - Epi Pens and Asthma Inhaler Permission Form completely filled out and signed by Parent and Licensed Medical Personnel (Parental signature allows camper to carry epi pen/inhaler, doctor's signature indicates camper can self-administer.)

_____ *Health Form complete* *Date* _____ *Your initials here* _____

IMPORTANT INFORMATION REGARDING MEDICATIONS TO BE TAKEN AT CAMP.....

1. Any medication that your Medical Provider requires to be administered at camp must be in its original pharmacy container labeled with the name of the person, name of the medication, dosage, and frequency of administration. Please send only the correct amount of medication. Your physician's written authorization to administer medications *both prescribed and over-the-counter* meds not on the OCD list must appear on the green health form.
2. All medicines are kept in the Health Center and administered by our nurses. The exceptions are: off-camp trips when Calumet staff give the medications under the direction of the nurse; asthma inhalers and epi-pens with the written authorization from your Health Care Provider for self-administration.
3. Do not send non-prescription medications (this includes vitamins, Tylenol, cold remedies, etc.). Our Health Center is well stocked with first aid and other medications for any conditions that might arise.
4. All medications should be picked up at the Health Center by a person age 18 or older before departing for home. All medications not picked up will be destroyed.

Calumet
PO Box 236
West Ossipee, NH 03890
603 539-3223 Fax 603 539-3385

PARENTAL PERMISSION AND MEDICAL RELEASE

Important - Must be completed for attendance*

Parent/Guardian Authorizations:

The health history in this form is correct and complete as far as I know. The person herein named has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for me/my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

It is my intention that the camp be treated as acting *in loco parentis* if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996.

I hereby agree to the disclosure to camp representatives of the Protected Health Information of the person here-in described, as necessary: (i) To provide relevant information to the camp representatives related to the person's ability to participate in camp activities; and (ii) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child's health status.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by Calumet to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for use off camp.

I give permission for my child to be given the Over-the-Counter medications listed below (or generic equivalent), if needed, while at Calumet. Doses to be administered as per package directions. I have crossed off any medications I do not want my child to be given.

Over-the-Counter (OTC) Medication Regulations

| | | |
|----------------------------|----------------------------|----------------------------|
| Acetaminophen | Diphenhydramine (Benadryl) | Milk of Magnesia |
| Antifungal powder or cream | Epinephrine for treatment | Phenylephrine (Sudafed PE) |
| Aurogan (for ear pain) | of anaphylaxis(epi pen) | Pseudoephedrine (Sudafed) |
| Bacitracin | Hydrocortisone Cream | Robitussin |
| Balmex | Ibuprofen (Motrin, Advil) | Robitussin DM |
| Calamine/Caladryl Lotion | Immodium | Sore Throat Lozenges |
| Cough Drops | Loratadine (Claritin) | Tums |

With my signature I agree to the above parent/guardian authorizations and give my child permission to participate in all Calumet activities and programs.

Camper/Adult/Staff Name _____

↓Signature of Parent/Guardian or Adult Camper/Staffer ↓

Signature _____

Print Name _____ Date _____

*If for religious reasons you cannot sign this, contact the camp for a legal waiver, which must be signed for attendance.

Health History – Camper/Staff Name: _____

The following information must be filled in by the parent/guardian, or adult camper or staff member. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records.

ALLERGIES List all known and describe reaction and management of the reaction.

Medication allergies (list)

Food allergies (list)

Other allergies (list) - include insect stings, hay fever, asthma, animal dander, etc.

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware. Have there been any recent family stresses – births, deaths, illnesses, moves, separations, divorces – that will impact their camp interactions or participation? Are there strategies that have helped the camper cope with concerns in the past?

**Calumet
PO Box 236
West Ossipee, NH 03890
603 539-3223 Fax 603 539-3385**

General Questions (Explain "yes" answers below.) **Camper/Staff Name:** _____

Has or does the participant:

- | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> 1. Have diabetes?</p> <p><input type="checkbox"/> <input type="checkbox"/> 2. Have asthma?</p> <p><input type="checkbox"/> <input type="checkbox"/> 3. Ever had an eating disorder?</p> <p><input type="checkbox"/> <input type="checkbox"/> 4. Ever had emotional difficulties</p> <p><input type="checkbox"/> <input type="checkbox"/> 5. Had any recent injury, illness or infectious disease?</p> <p><input type="checkbox"/> <input type="checkbox"/> 6. Have a chronic or recurring illness / condition?</p> <p><input type="checkbox"/> <input type="checkbox"/> 7. Ever been hospitalized?</p> <p><input type="checkbox"/> <input type="checkbox"/> 8. Ever had surgery?</p> <p><input type="checkbox"/> <input type="checkbox"/> 9. Have frequent headaches?</p> <p><input type="checkbox"/> <input type="checkbox"/> 10. Ever had a head injury?</p> <p><input type="checkbox"/> <input type="checkbox"/> 11. Ever been knocked unconscious?</p> <p><input type="checkbox"/> <input type="checkbox"/> 12. Wear glasses, contacts, or protective eye wear?</p> <p><input type="checkbox"/> <input type="checkbox"/> 13. Ever had frequent ear infections?</p> <p><input type="checkbox"/> <input type="checkbox"/> 14. Ever passed out during or after exercise?</p> <p><input type="checkbox"/> <input type="checkbox"/> 15. Ever been dizzy during or after exercise?</p> | <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> 17. Ever had chest pain during or after exercise?</p> <p><input type="checkbox"/> <input type="checkbox"/> 18. Ever had high blood pressure?</p> <p><input type="checkbox"/> <input type="checkbox"/> 19. Ever been diagnosed with a heart murmur?</p> <p><input type="checkbox"/> <input type="checkbox"/> 20. Ever had back problems?</p> <p><input type="checkbox"/> <input type="checkbox"/> 21. Ever had problems with joints (e.g., knees, ankles)?</p> <p><input type="checkbox"/> <input type="checkbox"/> 22. Have an orthodontic appliance being brought to camp?</p> <p><input type="checkbox"/> <input type="checkbox"/> 23. Have any skin problems (e.g., itching, rash, acne)?</p> <p><input type="checkbox"/> <input type="checkbox"/> 24. Had mononucleosis in the past 12 months?</p> <p><input type="checkbox"/> <input type="checkbox"/> 25. Have problems with diarrhea or constipation?</p> <p><input type="checkbox"/> <input type="checkbox"/> 26. Have problems with sleepwalking?</p> <p><input type="checkbox"/> <input type="checkbox"/> 27. If female, have an abnormal menstrual history?</p> <p><input type="checkbox"/> <input type="checkbox"/> 28. Have a history of bed-wetting?</p> |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Please explain any "yes" answers, noting the number of the questions.

Which of the following has the participant had?

- Measles
- Chicken Pox
- German Measles
- Mumps
- Hepatitis A
- Hepatitis B
- Hepatitis C

Please give all dates of immunization for:

| Vaccine: | Dates: | Mo/Yr | Mo/Yr | Mo/Yr | Mo/Yr | Mo/Yr |
|-------------------------|--------|-------|-------|-------|-------|-------|
| DTP | | _____ | _____ | _____ | _____ | _____ |
| TD (tetanus/diphtheria) | | _____ | _____ | _____ | _____ | _____ |
| Tetanus | | _____ | _____ | _____ | _____ | _____ |
| Polio | | _____ | _____ | _____ | _____ | _____ |
| MMR | | _____ | _____ | _____ | _____ | _____ |
| or Measles | | _____ | _____ | _____ | _____ | _____ |
| or Mumps | | _____ | _____ | _____ | _____ | _____ |
| or Rubella | | _____ | _____ | _____ | _____ | _____ |
| Haemophilus Influenza B | | _____ | _____ | _____ | _____ | _____ |
| Hepatitis B | | _____ | _____ | _____ | _____ | _____ |
| Varicella (chicken pox) | | _____ | _____ | _____ | _____ | _____ |

TB Mantoux Test Date of last test _____ Result: Positive Negative

Name of family physician _____ **Phone** (____) _____

Address _____

Name of family dentist/orthodontist _____ **Phone** (____) _____

Address _____

Health Care Recommendations by Licensed Medical Personnel

➤ Health Care Provider's standardized form can substitute for this page IF the information below is included. Please attach.

Camper / Adult / Staff Name: _____

* I EXAMINED THIS INDIVIDUAL ON _____ (DATE).

(ACA accreditation and State of NH requirements specify exams within 24 months of camp attendance.)

BP _____ Weight _____ Height _____

In my opinion, the above applicant is is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions _____

Recommendations and Restrictions at Camp

• Treatment to be continued at camp _____

• Medications to be administered at camp (name, dosage, frequency) _____

• Any medically-prescribed meal plan or dietary restrictions _____

• Known allergies _____

• Description of any limitation or restriction on camp activities _____

• Additional information for health care staff at the camp _____

Signature of Licensed Medical Personnel

*Signature _____

*Print Name _____

*Title _____ *Date _____

*Address _____

*Phone _____ *Fax _____

ASTHMA INHALER AND EPI PEN PERMISSION FORM

Pursuant to NH Law the following must be completed and submitted 3-weeks prior to attendance in order for your child to possess and use an asthma inhaler or epinephrine auto-injector this summer.

| |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Camper/Adult/Staff Name: _____</p> <p>Date of Birth _____</p> <p>Permission is granted to Camp Calumet to allow my child to possess and use</p> <p><input type="checkbox"/> Asthma inhaler / <input type="checkbox"/> Epinephrine Auto-Injector</p> <p>Parent / Guardian Signature _____</p> <p>Print name _____</p> <p>Date _____</p> |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

LICENSED MEDICAL PERSONNEL must complete the following for use of the above

Asthma inhaler / Epinephrine Auto-Injector

- 1) Name of medication _____
- 2) Date of Medication Order _____
- 3) Route and Dosage of Medication _____
- 4) Frequency and Time of Medication Administration or Assistance _____
- 5) Diagnosis and Any Other Medical Conditions Requiring Medications _____
- 6) Any Special Side Effects, Contraindications and Adverse Reactions to be observed? _____
- 7) Any severe adverse reactions that may occur to another child for whom the epinephrine auto-injector is not prescribed, should such a child receive a dose of medication? _____
- 8) Name of each required medication _____

I hereby verify that _____ has a valid prescription, and the knowledge and skills to safely possess and use the following at Camp Calumet:

Asthma Inhaler Epinephrine Auto-Injector

Licensed Medical Personnel Signature _____
Date _____ Print name _____
Business Phone (_____) _____ Emergency Phone (_____) _____

If any of these criteria are not met, Calumet will not be able to allow your child to carry or store in the cabin/tent his/her asthma inhaler or epi-pen. If you or your child's physician has any questions regarding this policy, please contact Calumet.