Berkshire Hills 2024 CAMPER Health Exam Form

Name: _____ DOB: _____/_____/_____ Age at camp: _____

Health Care Recommendations by Licensed Medical Personnel

Examination Date: _____/_____/_____ Weight: _____ Height: _____

In my opinion, this child is able to participate in an active camp program.

This child is under the care of a physician for the following conditions and the physician has the following recommendations and/or restrictions for the camper's time at camp (please include allergies/special diet):

_____

_____

My child requires an EpiPen: Yes_____ **No** _____ (Please provide camp with **TWO** EpiPens)
EpiPen Name: _____

*****Date of last TETANUS shot ____/____/____ (must be within 10 years)*****

MEDICATION: My child's physician and I give camp permission to administer all of the following medications in generic or brand form as available based on the dosage, schedule, and for the indications per medication label instructions. **ANY MEDICATION TAKEN DAILY BY YOUR CHILD MUST BE ORDERED THROUGH OUR MEDICATION SERVICE** which packages medicines into individual doses.

Over The Counter (OTC) Medications: *These are stocked by camp in case of illness.*
****PLEASE CROSS OUT ANY OTCs YOU DO NOT WANT YOUR CHILD TO HAVE****

Dramamine	Acetaminophen	Zyrtec	Allegra	Sudafed	Mylanta	MiraLax	Throat Lozenges
Bonine	Ibuprofen	Claritin	Benadryl	Robitussin	Pepto Bismol	Tums	Aloe Vera

Please list ANY OTHER MEDICATION to be taken by your child. All DAILY medications in pill form must be ordered through our medication service. **WE CANNOT GIVE YOUR CHILD ANY MEDICATION NOT LISTED ABOVE OR BELOW**

Rx Medications	Dosage/Schedule	OTCs (taken DAILY only)	Dosage/Schedule

>>> SIGNATURE OF LICENSED PHYSICIAN: _____
Printed Name: _____ Date: ____/____/____ Phone: _____
Address: _____

This health history is correct and accurately reflects the health status of my child, and I give permission to administer all medications listed above. My child has permission to participate in all camp activities except as noted by me and /or an examining physician. I give permission to the physician selected by camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give permission to the physician to hospitalize, secure proper treatment for, and order injections, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child, and these providers may talk with the program's staff about my child's health status.

>>> PARENT SIGNATURE: _____

Print Name: _____