INDIAN SPRINGS DAY CAMP
Camper Health Form

Submission Deadline: June 1

Required for ALL campers every year

Submit form to indiansp@indianspringsdaycamp.com OR upload to your Active account (where you registered your camper)

Before You Begin: Please **complete the checklist** below before submitting your health packet. This ensures all state-mandated requirements are met & our nursing staff can provide the best care for your camper.

- ☐ **Section 1: Parent/Guardian Information** (Completed and signed by parent/guardian)
- ☐ **Section 2: Healthcare Provider Examination** (Completed and signed by a licensed provider) *Note: An annual physical examination form is acceptable in place of Section 2 if it contains all health details, but **Section 1 and Standing Order for Over-the-counter Medications** still must be signed by parent/guardian & healthcare provider*
- ☐ **Updated Immunization Record** (Required for all campers)
- ☐ **Section 3: Authorization for Medication Administration**

(Required only for campers with asthma, severe allergies, seizures, or diabetes or any other chronic illness that requires having additional medication at camp.)

MUST provide an Emergency Action Plan dated on/after September 1st of last year

What is an Emergency Action Plan (EAP) : An Emergency Action Plan is a written set of instructions from your child's healthcare provider that tells camp staff exactly what to do if your child has a medical emergency.

Does my child need/have one? Your child needs an Emergency Action Plan if they have a medical condition that may require emergency medication or immediate treatment while at camp, such as:

- Asthma (rescue inhaler)
- Severe allergies/anaphylaxis (EpiPen)
- Seizure disorder
- Diabetes
- Any other condition requiring emergency medication or emergency care

If your child has one at school or your healthcare provider has given you one, please submit a copy with your camper's health forms. If you're unsure whether your child needs an Emergency Action Plan, please ask your child's healthcare provider.

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SECTION 1
Parent/Guardian Information

Who completes this section? *Parent or Legal Guardian*

Camper Name: _____ **DOB:** _____ **Age:** _____ **Gender: M / F**

Does your child have a preferred name or nickname? If so, what is it? _____

Primary Contacts (click in Name and Phone Number box to type)

Contact	Name	Phone Number
Parent/Guardian #1		
Parent/Guardian #2		
Emergency Contact #1		
Emergency Contact #2		

Medical & Insurance Information

Healthcare Provider/Practice Name: _____ Phone: _____

Insurance Provider: _____ Policy #: _____

Parent Assessment of Camper Health

1. List any chronic or recurring illnesses (physical/emotional) : _____
2. List behavioral/emotional/learning concerns: _____
3. Specific activity restrictions: _____
4. Strategies that help your child succeed: _____
   _____
   _____

Parent Authorization - MUST BE SIGNED

I certify that the information provided is accurate. I authorize my child to participate in all activities except as noted above. I authorize Indian Springs Day Camp staff to administer medications as ordered by my child's healthcare provider below. In the event of an emergency where I cannot be reached, I authorize emergency medical treatment as deemed necessary. **Parent/guardian will ALWAYS be called before any medication is administered**

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____

Did you remember to attach your camper's immunization record?

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SECTION 2
Healthcare Provider Examination

Who completes this section? *Licensed Healthcare Provider*

Clinical Findings *(Click in box to type directly or complete manually)*

Camper HEIGHT _____ / WEIGHT_____ :

System	Normal	Abnormal Findings / Recommendations
Vision	☐	
Hearing	☐	
Mobility	☐	
General Health	☐	

Allergies

None Identified ☐

- **Allergy Identified** ☐: _____
- Severity: Mild ☐ | Moderate ☐ | Severe ☐
- Reaction: _____

Standing Orders for Over-the-Counter Medications

Please indicate if the following may be administered PRN for minor illnesses/injuries:

- ☐ **Diphenhydramine (Benadryl):** ____ mg PO every ____ hours PRN

– OR –

- ☐ **Ceterizine (Zyrtec):** ____ mg PO every ____ hours PRN
- ☐ **Acetaminophen (Tylenol):** ____ mg PO every ____ hours PRN
- ☐ **Ibuprofen (Advil/Motrin):** ____ mg PO every ____ hours PRN
- ☐ **Pepto Kids Gummies** ____ gummy(ies) PO every ____ hours PRN for occasional upset stomach, indigestion, gas, or nausea.

Provider Certification

I have examined this camper and believe they are physically able to participate in camp activities except as noted. I have reviewed the above list of over-the-counter medications and indicated the ones appropriate for this camper should the need arise including recommended dosages.

Provider Signature: _____ Date: _____

Printed Name: _____ Phone: _____

** **Provider Practice STAMP alone is not sufficient. MUST be signed by a licensed Healthcare Provider**

Remember to check for all signatures and submit to camp by June 1st !

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SECTION 3
Authorization for Medication Administration

Who completes this section? *Healthcare Provider and Parent*

Only complete this section if the child requires scheduled or emergency medication at camp.

This is NOT for the over-the-counter medications in Section 2.

Scheduled Medications

Medication	Dosage	Route	Time	Reason
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Emergency Medication Status

Required for: ☐ Epinephrine | ☐ Rescue Inhaler | ☐ Glucagon | ☐ Seizure Rescue

- Camper authorized to self-carry ☐ Yes | ☐ No
  (Diabetes management meds, EpiPens, inhalers ONLY)
- Camper authorized to self-administer: ☐ Yes | ☐ No
  (Diabetes management meds, EpiPens, inhalers ONLY)

Provider Signature: _____ **Date:** _____
Printed Name: _____ Phone: _____

By signing below, parent requests the administration of the above-named medication(s) as prescribed by the authorizing healthcare provider AND acknowledges their consent to permit their camper to self-carry and/or self-administer diabetic management medications/supplies, emergency medications, as determined by the provider's authorization stated above.
Camper must demonstrate administration competency to camp nurse

Parent/Guardian Signature: _____ **Date:** _____
Printed Name: _____

An Emergency Action Plan MUST be submitted to camp for all campers requiring Section 3 (for Anaphylaxis, asthma, seizures or diabetes) dated ON or AFTER September 1st of last year.
New medication orders are required every summer.
All medication MUST be delivered to the nurse's office by parent/guardian in a secure original pharmacy-labeled container with CAMPER NAME. Please check expiration dates.

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