



Tamarack Country Club 2019 Medical Release Form

***Must be signed by the parent and physician**

Camper's Name: _____ Date of Birth _____

Address: _____

By signing this form, I certify that I accept complete responsibility for the health of my child and that, to the best of my knowledge, the camper is in good health.

I understand that should my child become injured or ill and I/we or my/our designate cannot be reached by the Camp director, my/our child will be taken by camp staff to the Greenwich Hospital Emergency Room for appropriate treatment for which I will be financially responsible. I understand that medical care, with the exception of simple first-aid measures, such as cleansing of cuts or scratches, placement of bandages, etc. will not be provided by camp personnel or physicians for the purpose of providing medical care to campers.

Signature of Parent/Guardian: _____ Date _____

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By signing this form, I certify that I have examined the above camper within the past 36 months and that (s)he was capable of participating in normal physical activities as of that date.

I certify that the above camper has been adequately immunized against diphtheria, tetanus, pertussis, polio, measles, rubella and any other diseases specified in Section 10-204a of the Regulations of Connecticut State.

\_\_\_\_\_  
Signature State License Number:  
(Doctor, R.N. or Physician's Assistant)

Date: \_\_\_\_\_ Concerns: \_\_\_\_\_

***PLEASE RETURN AND ENCLOSE A COPY OF YOUR CHILD'S IMMUNIZATION RECORDS WITH THIS COMPETED FORM on or before June 1, 2019.***

## Authorization for the Administration of Medication

In Connecticut, licensed Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the CT State Statutes and Regulations. Parents/guardians requesting medication administration to their child while at camp shall provide the program with appropriate written authorization(s) and the medication before any medications are administered. Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and date of the prescription. All unused medication shall be destroyed if not picked up within one week following the camper's departure at the end of camp.

### **Authorized Prescriber's Order (Physician, Dentist, Physician Assistant, Advanced Practice Registered Nurse):**

Name of Child \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Medication Name \_\_\_\_\_ Controlled Drug?  YES  NO

Dosage \_\_\_\_\_ Method \_\_\_\_\_ Time of Administration \_\_\_\_\_

Specific Instructions for Medication Administration \_\_\_\_\_

Medication Administration: Start Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Stop Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Is this medication to be self-administered by the child?  Yes  No

Relevant Side Effects of Medication \_\_\_\_\_

Plan of Management for Side Effects \_\_\_\_\_

Known Food or Drug Allergies?  YES  NO Reactions to?  YES  NO Interactions with?  YES  NO

If "yes" to any of the above, please explain \_\_\_\_\_

Prescriber's Name \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

Prescriber's Address \_\_\_\_\_ Town \_\_\_\_\_

Prescriber's Signature \_\_\_\_\_

### **Parent/Guardian Authorization:**

I request that medication be administered to my child as described and directed above.

Name of Camp \_\_\_\_\_ Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Child's Name \_\_\_\_\_ Address \_\_\_\_\_ Town \_\_\_\_\_

Name of Parent/Guardian Authorizing Administration of Medication as described and directed above:

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Relationship to Child:  Mother  Father  Guardian/Other explain: \_\_\_\_\_

Address \_\_\_\_\_ Town \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

Signature of Parent/Guardian Authorizing Administration of Medication \_\_\_\_\_

**Name of Camp Personnel Receiving Written Authorization and Medication** \_\_\_\_\_

**Title/Position** \_\_\_\_\_ **Signature (in ink)** \_\_\_\_\_