RUTGERS PRE-COLLEGE SUMMER PROGRAMS
INSTRUCTIONS FOR COMPLETING AND SUBMITTING REQUIRED MEDICAL FORMS

Dear Parents and Students,

Thank you for taking the time to review, complete and submit the medical forms contained in this packet. Rutgers University considers the well-being of your child our highest priority. Please feel free to contact us should you have questions or concerns.

Thank you,
Christopher Kenniff
Director, Mason Gross Extension Division

GENERAL GUIDELINES

- The due date for all medical forms is June 5, 2017.
- Who must submit these forms?
  - ALL summer program participants.
- Must ALL participants submit ALL forms?
  - Yes, with the following exceptions:
    - Certain forms are identified as being only for individuals participating in specific camps. All others should disregard these forms.
    - Forms that are identified as being necessary to submit only if needed.
- All physical evaluations/forms must be dated within one year of attending the summer program.
- Use only the forms supplied in this package. Substitute forms will not be accepted.
- Medical forms must be submitted via Certified Mail. We will not accept via email, fax, in-person hard-copy submissions or via upload/file sharing.
- Late, missing, incomplete forms or forms unsigned by a physician may result in you/your child not being able to participate in classes or move into the dorms (if registered as a resident).
- If you have specific questions regarding medication, please contact our camp nurse, Rose Currie: extdiv.nurse@gmail.com.
- If you have specific questions regarding dietary needs, please contact our camp nutritionist, Peggy Policastro: peggyp@rutgers.edu.

INSTRUCTIONS

1. Print all pages in this package.
2. Parent/Guardian: Fill out and sign (in ink) Section I of the Universal Child Health Form
3. Parent/Guardian: Fill out and sign (in ink) the following sections of the **Preparticipation Physical Evaluation Form** *(DANCE CAMP PARTICIPANTS ONLY!)*
   a. **History Form** (and if necessary, the **Please explain all “yes” answers page.**)
   b. **Supplemental History Form**

4. If your child has special medical or dietary needs:
   a. Read the **Summer Camps/Groups Specialized Dietary Needs Procedure** page
   b. Parent/Guardian fill out (in ink) Section I of the **Summer Camps and Groups Medical & Dietary Considerations** form.

5. Bring the following forms to your child’s doctor/health care provider to complete and sign:
   a. **Universal Child Health Record** and **Authorization for Administration of Medication Administration by School, Child Care, and Youth Camp Personnel**
   b. Dance Conservatory participants only: **Preparticipation Physical Evaluation** form comprised of the following:
      i. **History Form**
      ii. **Supplemental History Form**
      iii. **Physical Evaluation Form** (to be filled out and signed by the doctor)
      iv. **Clearance Form** (to be filled out and signed by the doctor)
      v. Complete ONLY if you have special medical/dietary needs requiring accommodation / special consideration: **Summer Camps and Groups Medical & Dietary Considerations** (Section II to be filled out and signed by the doctor) and **Food Allergy Action Plan**.
   c. Complete ONLY if your child has asthma: **Asthma Treatment Plan**.

6. While visiting your physician/health care provider:
   a. Review and complete the **Over the Counter Medication Distribution Form**
   b. Obtain a copy of your child’s most recent **Immunization Records**.
   c. **Obtain a prescription for additional medical necessities such as inhalers or epi-pens**. The student should pack one (inhaler, epi-pen or other necessity) in his/her bag and an additional should be provided for storage in the nurse’s office in the event of emergency.

7. Make a copy of the front and back of your **medical insurance card and prescription card**.

8. Parent/Guardian and Student: Sign and date (in ink) the **Permission to Treat Form**.

9. Photocopy all completed/signed forms for your own personal record.

10. Package the following completed/signed forms in a 9” x 12” envelope in the following order**
    a. **Universal Child Health Record** and **Authorization for Administration of Medication Administration by School, Child Care, and Youth Camp Personnel** form
    b. Immunization Record
    c. Photocopy of Insurance Card (front and back)
    d. Photocopy of Prescription Card (front and back)
    e. **DANCE CONSERVATORY ONLY**: **Preparticipation Physical Evaluation** including the following sections - History Form, Supplemental History Form, Physical Evaluation Form, Clearance Form
    f. **IF NECESSARY**: **Medical & Dietary Considerations Form** and **Food Allergy Action Plan**
    g. **IF NECESSARY**: **Asthma Treatment Plan** and **Over The Counter Medication Distribution Form Permission to Treat Form**
    h. A recent photo/headshot of your child/student (ex. school photo)

**Rutgers Pre-College Summer Programs will only accept envelopes with all of the above forms included and completed in entirety. Do not mail until all forms are complete/included.**

11. Address the envelope as follows:
    Mason Gross Extension Division
    Name of your summer program (i.e./ Rutgers Summer Jazz Institute)
    Rutgers University
12. Fill out a Certified Mail ticket at your local US Postal Office:
   a. Mason Gross Summer Programs will **ONLY ACCEPT CERTIFIED MAIL ENVELOPES**
      containing the required medical forms.
   b. Requires a small fee at the post office
   c. Retain the certified mail stub in order to be able to track your envelope and obtain
      confirmation of delivery.

13. If you filled out a **Medical & Dietary Considerations Form** and **Food Allergy Action Plan** you MUST
    ALSO fax or mail this form at least **TWO WEEKS PRIOR TO THE PROGRAM** to:

    **RU Express/board Plan Office Fax: 732-932-3915**
    **Records Hall, Room 102**
    **620 George Street**
    **New Brunswick, NJ 08901**

*Mason Gross is not responsible for forwarding your form to the RU Express/Board Plan Office. If dietary forms are not
submitted by the parent/guardian to the RU Express/Board Plan Office at least two weeks in advance of the program,
Rutgers Dining Services will not be able to supply a meal plan for the student and families will be responsible/required
to provide all meals for their children.*
# UNIVERSAL CHILD HEALTH RECORD

**Endorsed by:** American Academy of Pediatrics, New Jersey Chapter  
New Jersey Academy of Family Physicians  
New Jersey Department of Health

## SECTION I - TO BE COMPLETED BY PARENT(S)

<table>
<thead>
<tr>
<th>Child’s Name (Last)</th>
<th>(First)</th>
<th>Gender</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Male</td>
<td>/ /</td>
</tr>
</tbody>
</table>

**Does Child Have Health Insurance?**
- [ ] Yes  
- [ ] No  

If Yes, Name of Child's Health Insurance Carrier

**Parent/Guardian Name**

**Home Telephone Number**

**Work Telephone/Cell Phone Number**

**I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.**

**Signature/Date**

This form may be released to WIC.

- [ ] Yes  
- [ ] No  

## SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

**Date of Physical Examination:**

**Results of physical examination normal?**
- [ ] Yes  
- [ ] No  

**Abnormalities Noted:**

<table>
<thead>
<tr>
<th>Weight (must be taken within 30 days for WIC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height (must be taken within 30 days for WIC)</td>
</tr>
<tr>
<td>Head Circumference (if &lt;2 Years)</td>
</tr>
<tr>
<td>Blood Pressure (if ≥3 Years)</td>
</tr>
</tbody>
</table>

**IMMUNIZATIONS**

| □ Immunization Record Attached | □ Date Next Immunization Due: |

**MEDICAL CONDITIONS**

- **Chronic Medical Conditions/Related Surgeries**
  - List medical conditions/ongoing surgical concerns:
  - [ ] None  
  - [ ] Special Care Plan Attached  
  - [ ] Comments

- **Medications/Treatments**
  - List medications/treatments:
  - [ ] None  
  - [ ] Special Care Plan Attached  
  - [ ] Comments

- **Limitations to Physical Activity**
  - List limitations/special considerations:
  - [ ] None  
  - [ ] Special Care Plan Attached  
  - [ ] Comments

- **Special Equipment Needs**
  - List items necessary for daily activities:
  - [ ] None  
  - [ ] Special Care Plan Attached  
  - [ ] Comments

- **Allergies/Sensitivities**
  - List allergies:
  - [ ] None  
  - [ ] Special Care Plan Attached  
  - [ ] Comments

- **Special Diet/Vitamin & Mineral Supplements**
  - List dietary specifications:
  - [ ] None  
  - [ ] Special Care Plan Attached  
  - [ ] Comments

- **Behavioral Issues/Mental Health Diagnosis**
  - List behavioral/mental health issues/concerns:
  - [ ] None  
  - [ ] Special Care Plan Attached  
  - [ ] Comments

- **Emergency Plans**
  - List emergency plan that might be needed and the signs/symptoms to watch for:
  - [ ] None  
  - [ ] Special Care Plan Attached  
  - [ ] Comments

**PREVENTIVE HEALTH SCREENINGS**

<table>
<thead>
<tr>
<th>Type Screening</th>
<th>Date Performed</th>
<th>Record Value</th>
<th>Type Screening</th>
<th>Date Performed</th>
<th>Note if Abnormal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hgb/Hct</td>
<td></td>
<td></td>
<td>Hearing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lead:</td>
<td>□ Capillary</td>
<td>□ Venous</td>
<td>Vision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB (mm of Induration)</td>
<td>□</td>
<td></td>
<td>Dental</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td>Developmental</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td>Scoliosis</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- [ ] I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.

**Name of Health Care Provider (Print)**

**Health Care Provider Stamp:**

**Signature/Date**
Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3638.

Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)
   - Weight - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
   - Height - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
   - Head Circumference - Only enter if the child is less than 2 years.
   - Blood Pressure - Only enter if the child is 3 years or older.

2. Immunization - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health, Vaccine Preventable Diseases Program at 609-826-4860.
   - The Immunization record must be attached for the form to be valid.
   - “Date next immunization is due” is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.

3. Medical Conditions - Please list any ongoing medical conditions that might impact the child's health and well being in the child care or school setting.
   - Note any significant medical conditions or major surgical history. If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow. A generic care plan (CH-15) can be downloaded at www.nj.gov/health/forms/ch-15.dot or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.
   - Medications - List any ongoing medications. Include any medications given at home if they might impact the child's health while in child care (seizure, cardiac or asthma medications, etc.). Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.

   PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration.

   Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may require separate permissions slips for prescription and OTC medications.

   c. Limitations to physical activity - Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.

   d. Special Equipment – Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.

   e. Allergies/Sensitivities - Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at www.pacnj.org or by phone at 908-687-9340.

   f. Special Diets - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.

   g. Behavioral/Mental Health issues – Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.

   h. Emergency Plans - May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.

4. Screening - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public health personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.
   - For lead screening state if the blood sample was capillary or venous and the value of the test performed.
   - For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
   - Scoliosis screenings are done biennially in the public schools beginning at age 10.

   This form may be used for clearance for sports or physical education. As such, please check the box above the signature line and make any appropriate notations in the Limitation to Physical Activities block.

5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)
   - Print the health care provider's name.
   - Stamp with health care site's name, address and phone number.

CH-14 (Instructions)
JUL 12
Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel

Parents/guardians requesting medication administration to their child 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.

Authorized Prescriber’s Order (Physician, Dentist, Optometrist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist):

<table>
<thead>
<tr>
<th>Name of Child/Student</th>
<th>Date of Birth</th>
<th>Today’s Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address of Child/Student</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Town</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication Name/Generic Name of Drug</td>
<td>Controlled Drug?</td>
<td>YES</td>
</tr>
<tr>
<td>Condition for which drug is being administered:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specific Instructions for Medication Administration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dosage</td>
<td>Method/Route</td>
<td></td>
</tr>
<tr>
<td>Time of Administration</td>
<td>If PRN, frequency</td>
<td></td>
</tr>
<tr>
<td>Medication shall be administered: Start Date:</td>
<td>End Date:</td>
<td></td>
</tr>
<tr>
<td>Relevant Side Effects of Medication</td>
<td>None Expected</td>
<td></td>
</tr>
<tr>
<td>Explain any allergies, reaction to/negative interaction with food or drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan of Management for Side Effects</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescriber’s Name/Title</td>
<td>Phone Number (__)</td>
<td></td>
</tr>
<tr>
<td>Prescriber’s Address</td>
<td>Town</td>
<td></td>
</tr>
<tr>
<td>Prescriber’s Signature</td>
<td>Date</td>
<td></td>
</tr>
<tr>
<td>School Nurse Signature (if applicable)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Parent/Guardian Authorization:

- I request that medication be administered to my child/student as described and directed above
- I hereby request that the above ordered medication be administered by school, child care and youth camp personnel and I give permission for the exchange of information between the prescriber and the school nurse, child care nurse or camp nurse necessary to ensure the safe administration of this medication. I understand that I must supply the school with no more than a three (3) month supply of medication (school only.)
- I have administered at least one dose of the medication with the exception of emergency medications to my child/student without adverse effects. (For child care only)

<table>
<thead>
<tr>
<th>Parent/Guardian Signature</th>
<th>Relationship</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent/Guardian’s Address</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Town</td>
<td>State</td>
<td></td>
</tr>
</tbody>
</table>

Home Phone # (__) - Work Phone # (__) - Cell Phone # (__) -

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse (if applicable) in accordance with board policy. In a school, inhalers for asthma and cartridge injectors for medically-diagnosed allergies, students may self-administer medication with only the written authorization of an authorized prescriber and written authorization from a student’s parent or guardian or eligible student.

<table>
<thead>
<tr>
<th>Prescriber’s authorization for self-administration:</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature</td>
<td>Date</td>
<td></td>
</tr>
<tr>
<td>Parent/Guardian authorization for self-administration:</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Signature</td>
<td>Date</td>
<td></td>
</tr>
<tr>
<td>School nurse, if applicable, approval for self-administration:</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Signature</td>
<td>Date</td>
<td></td>
</tr>
</tbody>
</table>

Today’s Date Printed Name of Individual Receiving Written Authorization and Medication |

Title/Position Signature (in ink or electronic)
STAPLE A COPY OF THE STUDENT'S

IMMUNIZATION RECORDS HERE
STAPLE A COPY OF MEDICAL INSURANCE CARD HERE

(FRONT AND BACK)

<table>
<thead>
<tr>
<th>FRONT</th>
<th>BACK</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

STAPLE A COPY OF MEDICAL PRESCRIPTION CARD HERE

(FRONT AND BACK)

<table>
<thead>
<tr>
<th>FRONT</th>
<th>BACK</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Preparticipation Physical Evaluation

## HISTORY FORM

(NoTe: This form is to be filled out by the student and parent (if student is under 18) prior to seeing the physician. The physician should keep this form in the chart.)

<table>
<thead>
<tr>
<th>Date of Exam ____________________________</th>
<th>Date of birth ____________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Name ____________________________**

**Gender ____________________________ Age ____________________________**

**Medicines and Allergies:** Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking.

<table>
<thead>
<tr>
<th>Medicines</th>
<th>Pollens</th>
<th>Food</th>
<th>Latex</th>
<th>Stinging Insects</th>
</tr>
</thead>
<tbody>
<tr>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
</tbody>
</table>

Do you have any allergies?  ❑ Yes  ❑ No  If yes, please identify specific allergy below.

**GENERAL QUESTIONS**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Has a doctor ever denied or restricted your participation in dance or sport activity for any reason?</td>
<td></td>
</tr>
<tr>
<td>2. Do you have any ongoing medical conditions? If so, please identify below:  ❑ Asthma  ❑ Anemia  ❑ Diabetes  ❑ Infections Other:</td>
<td></td>
</tr>
<tr>
<td>3. Have you ever spent the night in the hospital?</td>
<td></td>
</tr>
<tr>
<td>4. Have you ever had surgery?</td>
<td></td>
</tr>
<tr>
<td>5. Have you ever passed out or nearly passed out during or after exercise?</td>
<td></td>
</tr>
<tr>
<td>6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?</td>
<td></td>
</tr>
<tr>
<td>7. Does your heart ever race or skip beats (irregular beats) during exercise?</td>
<td></td>
</tr>
<tr>
<td>8. Has a doctor ever told you that you have any heart problems? If so, check all that apply:  ❑ High blood pressure  ❑ Heart murmur  ❑ High cholesterol  ❑ Heart infection  ❑ Kawasaki disease  ❑ Other:</td>
<td></td>
</tr>
<tr>
<td>9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)</td>
<td></td>
</tr>
<tr>
<td>10. Do you get lightheaded or feel more short of breath than expected during exercise?</td>
<td></td>
</tr>
<tr>
<td>11. Have you ever had an unexplained seizure?</td>
<td></td>
</tr>
<tr>
<td>12. Do you get more tired or short of breath more quickly than your friends during exercise?</td>
<td></td>
</tr>
</tbody>
</table>

**HEART HEALTH QUESTIONS ABOUT YOU**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death)?</td>
<td></td>
</tr>
<tr>
<td>14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arthrythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?</td>
<td></td>
</tr>
<tr>
<td>15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?</td>
<td></td>
</tr>
<tr>
<td>16. Has anyone in your family unexplained fainting, unexplained seizures, or near drowning?</td>
<td></td>
</tr>
</tbody>
</table>

**BONE AND JOINT QUESTIONS**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?</td>
<td></td>
</tr>
<tr>
<td>18. Have you ever had any broken or fractured bones or dislocated joints?</td>
<td></td>
</tr>
<tr>
<td>19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?</td>
<td></td>
</tr>
<tr>
<td>20. Have you ever had a stress fracture?</td>
<td></td>
</tr>
<tr>
<td>21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or other condition)</td>
<td></td>
</tr>
<tr>
<td>22. Do you regularly use a brace, orthotics, or other assistive device?</td>
<td></td>
</tr>
<tr>
<td>23. Do you have a bone, muscle, or joint injury that bothers you?</td>
<td></td>
</tr>
<tr>
<td>24. Do any of your joints become painful, swollen, feel warm, or look red?</td>
<td></td>
</tr>
</tbody>
</table>

**MEDICAL QUESTIONS**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>25. Do you cough, wheeze, or have difficulty breathing during or after exercise?</td>
<td></td>
</tr>
<tr>
<td>26. Have you ever used an inhaler or taken asthma medicine?  ❑ Yes  ❑ No</td>
<td></td>
</tr>
<tr>
<td>27. Have you ever had an asthma attack?  ❑ Yes  ❑ No</td>
<td></td>
</tr>
<tr>
<td>28. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?</td>
<td></td>
</tr>
<tr>
<td>29. Do you ever have or have you had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?</td>
<td></td>
</tr>
<tr>
<td>30. Do you have groin pain or a painful bulge or hernia in the groin area?</td>
<td></td>
</tr>
<tr>
<td>31. Have you had infectious mononucleosis (mono) within the last month?</td>
<td></td>
</tr>
<tr>
<td>32. Do you have any rashes, pressure sores, or other skin problems?  ❑ Yes  ❑ No</td>
<td></td>
</tr>
<tr>
<td>33. Have you had a herpes or MRSA skin infection?</td>
<td></td>
</tr>
<tr>
<td>34. Have you ever had a head injury or concussion?</td>
<td></td>
</tr>
<tr>
<td>35. Have you ever had polymorphic ventricular tachycardia?</td>
<td></td>
</tr>
<tr>
<td>36. Do you have a history of seizure disorder?</td>
<td></td>
</tr>
<tr>
<td>37. Do you have headaches with exercise?</td>
<td></td>
</tr>
<tr>
<td>38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?</td>
<td></td>
</tr>
<tr>
<td>39. Have you ever been unable to move your arms or legs after being hit or falling?</td>
<td></td>
</tr>
<tr>
<td>40. Have you ever become ill while exercising in the heat?</td>
<td></td>
</tr>
<tr>
<td>41. Do you get frequent muscle cramps during exercise?</td>
<td></td>
</tr>
<tr>
<td>42. Do you or someone in your family have sickle cell trait or disease?</td>
<td></td>
</tr>
<tr>
<td>43. Have you or anyone in your family had or have you ever had a heart attack?</td>
<td></td>
</tr>
<tr>
<td>44. Have you ever had heart disease?</td>
<td></td>
</tr>
<tr>
<td>45. Have you had a history of stroke?</td>
<td></td>
</tr>
<tr>
<td>46. Do you wear protective eyewear, such as goggles or a face shield?</td>
<td></td>
</tr>
<tr>
<td>47. Do you worry about your weight?</td>
<td></td>
</tr>
<tr>
<td>48. Are you trying to or has anyone recommended that you gain or lose weight?</td>
<td></td>
</tr>
<tr>
<td>49. Are you on a special diet or do you avoid certain types of foods?  ❑ Yes  ❑ No</td>
<td></td>
</tr>
<tr>
<td>50. Have you ever had a head injury or concussion?</td>
<td></td>
</tr>
<tr>
<td>51. Have you ever had or do you have a history of heart problems?</td>
<td></td>
</tr>
</tbody>
</table>

**FEMALES ONLY**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>52. Have you ever had a menstrual period?</td>
<td></td>
</tr>
<tr>
<td>53. How old were you when you had your first menstrual period?</td>
<td></td>
</tr>
<tr>
<td>54. How many periods have you had in the last 12 months?</td>
<td></td>
</tr>
<tr>
<td>55. When are you in a car (driving or riding as passenger) what percentage of the time do you wear your seat belt?</td>
<td></td>
</tr>
</tbody>
</table>

**Injury History Form**

**GENERAL QUESTIONS**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>56. Have you ever had a head injury or concussion?</td>
<td></td>
</tr>
<tr>
<td>57. Have you ever had any broken or fractured bones or dislocated joints?</td>
<td></td>
</tr>
<tr>
<td>58. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?</td>
<td></td>
</tr>
<tr>
<td>59. Have you ever had a stress fracture?</td>
<td></td>
</tr>
<tr>
<td>60. Have you ever had or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or other condition)</td>
<td></td>
</tr>
<tr>
<td>61. Do you regularly use a brace, orthotics, or other assistive device?</td>
<td></td>
</tr>
<tr>
<td>62. Do you have a bone, muscle, or joint injury that bothers you?</td>
<td></td>
</tr>
<tr>
<td>63. Do any of your joints become painful, swollen, feel warm, or look red?</td>
<td></td>
</tr>
</tbody>
</table>

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

**Signature of student ____________________________**

**Signature of parent/guardian (if student is under 18) ____________________________**

Date ____________________________

Preparticipation Physical Evaluation

PLEASE EXPLAIN ALL “YES” ANSWERS AND REFER TO QUESTIONS NUMBER

Supplemental History Form

Date of Exam ________________________________
Name ________________________________ Date of birth ________________________________
Gender ____ Age ______________

1. Type of disability
2. Date of disability
3. Classification (if available)
4. Cause of disability (birth, disease, accident/trauma, other)
5. List the activities you are interested in participating in?
   Yes __________ No __________

6. Do you regularly use a brace, assistive device, or prosthetic?
7. Do you use any special brace or assistive device for sports or dance activities?
8. Do you have any rashes, pressure sores, or any other skin problems?
9. Do you have a hearing loss? Do you use a hearing aid?
10. Do you have a visual impairment?
11. Do you use any special devices for bowel or bladder function?
12. Do you have burning or discomfort when urinating?
13. Have you had autonomic dysreflexia?
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?
15. Do you have muscle spasticity?
16. Do you have frequent seizures that cannot be controlled by medication?

Explain “yes” answers here

Please indicate if you have ever had any of the following.

Atlantoaxial instability Yes ______ No ______
X-ray evaluation for atlantoaxial instability
Dislocated joints (more than one)
Easy bleeding
Enlarged spleen
Hepatitis
Osteopenia or osteoporosis
Difficulty controlling bowel
Difficulty controlling bladder
Numbness or tingling in arms or hands
Numbness or tingling in legs or feet
Weakness in arms or hands
Weakness in legs or feet
Recent change in coordination
Recent change in ability to walk
Spina bifida
Latex allergy

Explain “yes” answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of student __________________________ Signature of parent/guardian __________________________ Date __________

# Preparticipation Physical Evaluation

## PHYSICAL EXAMINATION FORM

### PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?

2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

### EXAMINATION

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>Gender</th>
<th>BP</th>
<th>/</th>
<th>Pulse</th>
<th>Vision R 20/</th>
<th>L 20/</th>
<th>Corrected</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### MEDICAL

<table>
<thead>
<tr>
<th>Appearance</th>
<th>Normal</th>
<th>Abnormal Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span &gt; height, hyper laxity, myopia, MVP, aortic insufficiency)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Eyes/ears/nose/throat</th>
<th>Normal</th>
<th>Abnormal Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pupils equal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lymph nodes</th>
<th>Normal</th>
<th>Abnormal Findings</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Heart</th>
<th>Normal</th>
<th>Abnormal Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Murmurs (auscultation standing, supine, +/- Valsalva)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Location of point of maximal impulse (PMI)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pulses</th>
<th>Normal</th>
<th>Abnormal Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Simultaneous femoral and radial</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lungs</th>
<th>Normal</th>
<th>Abnormal Findings</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Abdomen</th>
<th>Normal</th>
<th>Abnormal Findings</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Genitourinary (males only)</th>
<th>Normal</th>
<th>Abnormal Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSV, lesions suggestive of MRSA, tinea corporis</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Skin</th>
<th>Normal</th>
<th>Abnormal Findings</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Neurologic</th>
<th>Normal</th>
<th>Abnormal Findings</th>
</tr>
</thead>
</table>

### MUSCULOSKELETAL

<table>
<thead>
<tr>
<th>Neck</th>
<th>Normal</th>
<th>Abnormal Findings</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Back</th>
<th>Normal</th>
<th>Abnormal Findings</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Shoulder/arm</th>
<th>Normal</th>
<th>Abnormal Findings</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Elbow/forearm</th>
<th>Normal</th>
<th>Abnormal Findings</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Wrist/hand/fingers</th>
<th>Normal</th>
<th>Abnormal Findings</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Hip/High</th>
<th>Normal</th>
<th>Abnormal Findings</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Knee</th>
<th>Normal</th>
<th>Abnormal Findings</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Leg/ankle</th>
<th>Normal</th>
<th>Abnormal Findings</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Foot/toes</th>
<th>Normal</th>
<th>Abnormal Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functional</td>
<td>Duck-walk, single leg hop</td>
<td></td>
</tr>
</tbody>
</table>

### Recommendations

- Cleared for all activities without restriction
- Cleared for all activities without restriction with recommendations for further evaluation or treatment for

- Not cleared
  - Pending further evaluation
  - For any sports and dance activities
  - For certain sports or dance activity

Reason: 

I have examined the above-named student and completed the preparticipation physical evaluation. The student does not present apparent clinical contraindications to practice and participate in the sport(s) and dance activity as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the student has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the student (and parents/guardians).

Name of physician (print/type) __________________________ Date ________________

Address __________________________ Phone __________________________

Signature of physician __________________________ MD or DO

---

Preparticipation Physical Evaluation

CLEARANCE FORM

Name __________________________________________ Gender ________ Age ________ Date of birth ________

☐ Cleared for all sports and dance activities without restriction

☐ Cleared for all sports and dance activities without restriction with recommendations for further evaluation or treatment for __________________________________________________________

☐ Not cleared

☐ Pending further evaluation

☐ For any dance or sports activities

☐ For certain dance or sports activity

Recommendations __________________________________________________________

________________________________________________________

________________________________________________________

I have examined the above-named student and completed the preparticipation physical evaluation. The student does not present apparent clinical contraindications to practice and participate in the sport(s) and dance activity as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the student has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the student (and parents/guardians).

Name of physician (print/type) __________________________ Date __________

Address __________________________________ Phone __________

Signature of physician __________________________, MD or DO

EMERGENCY INFORMATION

Allergies __________________________________________________________

________________________________________________________

________________________________________________________

________________________________________________________

Other information __________________________________________________________

________________________________________________________

________________________________________________________

________________________________________________________

________________________________________________________

**Important Notes:**

1. All sections of this form must be completed before the request can be processed.
2. This form must be received by the Dining Services Nutritionist at least **TWO WEEKS** prior to the first day of camp. Special dietary requests received after the two week period may not be honored.
3. Completion of this form will initiate a professional review of your nutritional and dietary concerns. Dining Services will work with camper/group member who have special dietary needs to ensure a medically appropriate and nutritionally sound diet.
4. After all sections of the form are completed, please **return it to your camp/group director**. It will then be forwarded to the Dining Services Nutritionist who will contact the camper/parent/group member indicated to discuss individual dietary needs.

**I. TO BE COMPLETED BY THE CAMPER/GROUP MEMBER (OR GUARDIAN)**

**NAME:** ____________________________________________

**CONTACT PERSON:**

**PHONE #:** ____________________________

**EMAIL ADDRESS:** ____________________________________________

**NAME OF CAMP/GROUP:** ____________________________

**DATE(S) OF CAMP/GROUP:** ____________________________

Please describe the specialized dietary adjustments required:

_________________________________________________________________

_________________________________________________________________

**II. TO BE COMPLETED BY PRIVATE PHYSICIAN**

Describe briefly your medical findings regarding the individual’s illness and special dietary adjustments required.

_________________________________________________________________

_________________________________________________________________

Physician’s Signature: ____________________________

Date: ____________________________

Print Physician’s Name: ____________________________

Address: ____________________________

Phone #: ____________________________

Fax#: ____________________________

Please suggest dining/nutritional accommodations to be considered for this individual: ____________________________

Physician Signature: ____________________________

Date: ____________________________

Dining Services is only responsible for dietary accommodations for meals prepared and served through Rutgers Dining Services. All meals received from outside vendors/facilities will not be verified by the Dining Services Nutritionist.
RUTGERS HEALTH SERVICES
PERMISSION TO DIAGNOSE AND TREAT

New Jersey State Law requires that parental permission be obtained in advance for the diagnosis/treatment of a Minor. This consent form should be signed by a parent or Legal Guardian so that prompt, routine medical care may be delivered without unnecessary delay to a student while he/she is attending a program/conference through Rutgers, the State University of New Jersey.

I, ___________________________, give permission for the staff at Rutgers Health Services (Medical Practitioner/Registered Nurse) to perform a diagnostic evaluation and provide therapeutic treatment of an illness/injury, or referral for diagnosis or treatment, as deemed necessary for my son/daughter, ____________________________.

I certify by my signature that I understand the nature of this consent and agree to its provisions.

_____________________________  ______________________________
Signature of Parent/Legal Guardian  Date

_____________________________
Relationship to Minor

_____________________________
Signature of Minor
STAPLE A PHOTO/HEADSHOT OF YOUR CHILD/STUDENT HERE

(EX: SCHOOL PHOTO)
Food Allergy Action Plan

Student’s Name: 
D.O.B: 
Teacher: 

ALLERGY TO: ____________________________________________

Asthmatic Yes* No  *Higher risk for severe reaction

◆ STEP 1: TREATMENT ◆

Symptoms:
- If a food allergen has been ingested, but no symptoms:
- Mouth: itching, tingling, or swelling of lips, tongue, mouth
- Skin: hives, itchy rash, swelling of the face or extremities
- Gut: nausea, abdominal cramps, vomiting, diarrhea
- Throat†: tightening of throat, hoarseness, hacking cough
- Lung†: Shortness of breath, repetitive coughing, wheezing
- Heart†: Thready pulse, low blood pressure, fainting, pale, blueness
- Other†: ____________________________________________

If reaction is progressing (several of the above areas affected), give

The severity of symptoms can quickly change. †Potentially life-threatening.

DOSAGE
Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg (see reverse side for instructions)

Antihistamine: give ________________________________ medication/dose/route

Other: give ________________________________ medication/dose/route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911 (or Rescue Squad: ________________________________). State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. ________________________________ at ________________________________

3. Emergency contacts:
   Name/Relationship Phone Number(s)
   a. ________________________________ 1.) ________________________________ 2.) ________________________________
   b. ________________________________ 1.) ________________________________ 2.) ________________________________
   c. ________________________________ 1.) ________________________________ 2.) ________________________________

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian Signature ________________________________ Date ________________________________

Doctor’s Signature ________________________________ (Required) Date ________________________________
EpiPen® and EpiPen® Jr. Directions

- Pull off gray activation cap.
- Hold black tip near outer thigh (always apply to thigh).
- Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.

Twinject™ 0.3 mg and Twinject™ 0.15 mg Directions

- Pull off green end cap, then red end cap.
- Put gray cap against outer thigh, press down firmly until needle penetrates. Hold for 10 seconds, then remove.

SECOND DOSE ADMINISTRATION:
If symptoms don’t improve after 10 minutes, administer second dose:
- Unscrew gray cap and pull syringe from barrel by holding blue collar at needle base.
- Slide yellow or orange collar off plunger.
- Put needle into thigh through skin, push plunger down all the way, and remove.

Once EpiPen® or Twinject™ is used, call the Rescue Squad. Take the used unit with you to the Emergency Room. Plan to stay for observation at the Emergency Room for at least 4 hours.

For children with multiple food allergies, consider providing separate Action Plans for different foods.

**Medication checklist adapted from the Authorization of Emergency Treatment form developed by the Mount Sinai School of Medicine. Used with permission.**
Asthma Treatment Plan – Student

(Please Print)

Name

Date of Birth

Effective Date

Doctor

Parent/Guardian (if applicable)

Emergency Contact

Phone

Phone

HEALTHY (Green Zone)

You have all of these:

• Breathing is good
• No cough or wheeze
• Sleep through the night
• Can work, exercise, and play

And/or Peak flow above

Take daily control medicine(s). Some inhalers may be more effective with a “spacer” – use if directed.

MEDICINE HOW MUCH to take and HOW OFTEN to take it

• Advair® HFA 43, 115, 230 2 puffs twice a day
• Alvesco® 80, 180 1, 2 puffs twice a day
• Albuterol® 100, 200 2 puffs twice a day
• Flovent® 44, 110, 220 2 puffs twice a day
• Qvar® 40, 80, 160 1, 2 puffs twice a day
• Symbicort® 50, 160 1 inhalation twice a day
• Advair Diskus® 100, 250, 500 1 inhalation twice a day
• Asmanex® Twusither® 110, 220 1, 2 inhalations once or twice a day
• Flovent® Diskus® 50, 100, 250 1 inhalation twice a day
• Pulmicort Flexhaler® 90, 180 1, 2 inhalations once or twice a day
• Pulmicort Respules® (Budesonide) 0.25, 0.5, 1.0 1 unit nebulized once or twice a day
• Singular® (Montelukast) 4, 5, 10 mg 1 tablet daily

Other

None

Remember to rinse your mouth after taking inhaled medicine.

If exercise triggers your asthma, take __________ puffs (s) _______ minutes before exercise.

CAUTION (Yellow Zone)

You have any of these:

• Cough
• Mild wheeze
• Tight chest
• Coughing at night
• Other:

If quick-relief medicine does not help within 15-20 minutes or has been used more than 2 times and symptoms persist, call your doctor or go to the emergency room.

And/or Peak flow from __________ to __________

Continue daily control medicine(s) and ADD quick-relief medicine(s).

MEDICINE HOW MUCH to take and HOW OFTEN to take it

• Albuterol MDI (Pro-air® or Proventil® or Ventolin) 2 puffs every 4 hours as needed
• Xopenpy® 2 puffs every 4 hours as needed
• Albuterol 1.25, 2.5 mg 1 unit nebulized every 4 hours as needed
• Duodin® 1 unit nebulized every 4 hours as needed
• Xopenpy® (Levalbuterol) 0.25, 0.5, 1.25 mg 1 unit nebulized every 4 hours as needed
• Combivent Respimat® 1 inhalation 4 times a day

Other:

If quick-relief medicine is needed more than 2 times a week, except before exercise, then call your doctor.

EMERGENCY (Red Zone)

Your asthma is getting worse fast:

• Quick-relief medicine did not help within 15-20 minutes
• Breathing is hard or fast
• Nose opens wide • Ribs show
• Trouble walking and talking
• Lips blue • Fingernails blue
• Other:

And/or Peak flow below

Take these medicines NOW and CALL 911.

Asthma can be a life-threatening illness. Do not wait!

MEDICINE HOW MUCH to take and HOW OFTEN to take it

• Albuterol MDI (Pro-air® or Proventil® or Ventolin) 4 puffs every 20 minutes
• Xopenpy® 4 puffs every 20 minutes
• Albuterol 1.25, 2.5 mg 1 unit nebulized every 20 minutes
• Duodin® 1 unit nebulized every 20 minutes
• Xopenpy® (Levalbuterol) 0.31, 0.63, 1.25 mg 1 unit nebulized every 20 minutes
• Combivent Respimat® 1 inhalation 4 times a day

Other:

PHYSICIAN/PA/PA SIGNATURE ____________________________

PHYSICIAN’S ORDERS ____________________________

PARENT/GUARDIAN SIGNATURE ____________________________

PHYSICIAN STAMP ____________________________

Permission to Self-administer Medications:

□ This student is capable and has been instructed in the proper method of self-administering the non-nebulized inhaler medications named above in accordance with NJ Law.
□ This student is not approved to self-medicate.

PHYSICIAN’S SIGNATURE ____________________________

DATE ____________________________

This asthma treatment plan is meant to assist, not replace, the clinical decision-making related to meet individual patient needs.

Make a copy for parent and for physician file, send original to school nurse or child care provider.
Over the Counter (OTC) Medication Distribution Form

The following non-prescription medications are stocked in the camp nurses office and are used on an as needed basis to manage illness and injury. YOU DO NOT NEED TO SEND THESE TO CAMP, but we will NOT give any of these without your specific approval below. Indicate if your child may or may not be given these medications by CIRCLING “YES” or “NO” FOR EACH MEDICATION:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ibuprofen (Advil/Motrin)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acetaminophen (Tylenol)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excedrin Migraine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diphenhydramine (Benadryl)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tums</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pepto Bismol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antibiotic Cream</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hydrocortisone Cream 1%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Use this space to provide any additional information about the camper’s health that you think important or that may affect the camper’s ability to fully participate in the camp program.
_____________________________________________________________________________________
_____________________________________________________________________________________

PARENT/GUARDIAN
NAME: _____________________________________________
PHONE: __________________________________________
PARENT/GUARDIAN AUTHORIZATIONS FOR: _______________________________________________
(NAME OF CAMPER)

This health profile (including information provided in any attachment) is correct and accurately reflects the health status of the camper to whom it pertains. This camper has my permission to participate in all camp activities except as documented by me and/or the examining physician. The camp nurse(s) have permission to inform appropriate camp staff members of this camper’s medical condition(s) or individual needs on a “need to know” basis. I give permission to photocopy this form. I give permission to the physician(s) selected by the camp to order x-rays, routine test, and treatment related to the health of my child for emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize and secure proper treatment for this child. 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 camp’s staff about my child’s health status. I also give permission to the camp to arrange necessary medically-related transportation for this camper.

Signature of Parent/Guardian: __________________________________________________________

Printed Name: ____________________________ Date: ____________________________