

CAMP MEDICAL REQUIREMENTS

1. Each camper must provide documentation of a physical examination, including immunization record. The physical must be from within 3 years of the start date of camp, in order to be considered valid.
 - a. Your physician's physical form is acceptable. Contact your physician.
2. The following forms are required of every camper:
 - a. Medical History Information
 - b. Informed Consent and Permission to Participate
 - c. Proof of physical exam (i.e school physical form)
3. All campers and their parents should read carefully the camp medication policy. Physician authorization is required for anyone needing prescription or over-the-counter (OTC) drugs during camp. You will need to have a Medication Authorization form completed if you need medication of any type.
4. Mouthguards are required of all participants.
5. Protective eyewear is required for all participants. Protective eyewear must meet current ATSM lacrosse standards. Participants with eyeglasses will not be permitted to participate without appropriate protective eyewear.

INFORMED CONSENT & PERMISSION TO PARTICIPATE

RE: _____ Date of birth: _____
(Name of child)

I understand that the Lacrosse School staff will take every precaution to allow for safe participation by all athletes during lacrosse camp. The camp will involve strenuous physical activity. A certified athletic trainer will be present for all camp activities. I understand that participation in sports and strenuous physical activity involves the potential for injury, even when all precautions are taken. On rare occasions, injuries can be so severe as to result in total disability, paralysis, or death. I certify that my child is in excellent physical health, and may participate in strenuous physical activities. I understand and accept the risks associated with participation in sports and physical activity, and give permission for the above named child to participate in the Lacrosse School camp at Wesleyan University, July 5-7, 2008. (initials here ____)

Permission is granted for the participant to receive both immediate first aid and emergency medical treatment, and be transported to the closest hospital for treatment if necessary. (initials here ____)

I agree to indemnify and hold harmless the Lacrosse School, Wesleyan University, and all camp staff for all claims arising out of my child's participation in the camp. I understand that the Lacrosse School does not provide medical insurance for the camp. (initials here ____)

Medical Insurance Information:

Check one:

- [] I **DO NOT** have medical insurance that covers my child, and I agree to be fully liable for any and all medical costs incurred for treatment of an injury or medical condition sustained at camp. (initials here ____)
- [] I **DO** have medical insurance that covers my child, and I agree to be fully responsible for all costs that my medical insurance does not cover, for treatment of an injury or medical condition sustained at camp. (initials here ____)

I represent that I am the parent/legal guardian of the child named above, and agree that the terms of this release are binding on me and the child.

Parent/Legal Guardian Signature _____ Date _____

Print name _____ Relation to camper: _____

June, 2008

ALL CAMPERS & PARENTS: PLEASE READ!

Lacrosse School, LLC: Summer Lacrosse Camp Medication Policy

1. The Lacrosse School summer camp is licensed by the state of Connecticut, and is required to follow state guidelines and law pertaining to youth camps. Pursuant to those standards, campers are not permitted possess or self-administer any medications without written physician orders and parental permission on file.
2. Any camper who will need prescription or over-the-counter (OTC) medications to treat a medical condition during camp is required to have a Medication Authorization form on file, prior to participation in camp activities.
3. Medication storage
 - a. All medications must be stored in a secure area, by the camp Health Care Coordinator, per state law. Campers are not permitted to store their own medications.
 - b. All medications must be stored in the original, child-resistant safety container. The container or packaging **MUST** have a label, which includes the following information:
 - 1) child's name
 - 2) name of medication
 - 3) directions for medication's administration
 - 4) date of prescription or date of order for OTC medications
 - c. Individuals requiring immediate access to emergency medications will have these items available at all times. These arrangements will be made on an individual basis, prior to the start of camp.
4. The Camp Health Care Coordinator will supervise the administration of all medications. Campers who have physician orders and permission to self-administer medication will do so in the presence of the Health Care Coordinator, so that appropriate documentation can be maintained.
5. Medication administration guidelines will be reviewed with each camper who has physician orders for medications, at check-in. Medications will be turned over to the camp Health Care Coordinator at check-in.
6. All medications will be returned to the camper or camper's parent at check-out.
7. Failure to comply with this policy is grounds for expulsion from the camp.

June 2008

**AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATIONS
BY YOUTH CAMP PERSONNEL**

Connecticut State Law and Regulations require an authorized prescriber (M.D., P.A.-C., APRN) or dentist's written order AND parent or guardian authorization for camp personnel with current Medical Administration training to administer medications. Medications must be in pharmacy prepared containers and labeled with the name of the child, name of the drug, drug strength, dosage, frequency, authorized prescriber's name, and the date of the original prescription. Over the counter medication must be in the original container and labeled with the child's name.

AUTHORIZED PRESCRIBER OR DENTIST'S ORDER: Date

Name of child _____ Date of birth _____

Home address _____ City _____ State _____

Condition for which drug is being administered during camp hours _____

DRUG: Name of drug, dosage, and method of administration _____

Times of administration: _____, _____, _____, _____

Can child self-administer? (circle one) YES NO

Medication shall be administered from ____/____/2008 - ____/____/2008

Relevant side effects to be observed, if any _____

If there are side effects, plan for management _____

Is this a controlled drug? (circle one) YES NO

Allergies, reaction to, or negative interaction with food or drugs? (circle one) NO YES If YES, list _____

Authorized prescriber's name _____ Phone # (____) _____

Address _____ City _____ State _____

Authorized prescriber's signature _____

AUTHORIZATION BY PARENT/GUARDIAN for the administration of the above medication:

Date: _____ Name of child _____

I hereby request that the above medication, ordered by the authorized provider for my child, be administered by camp health care personnel with Medication Authorization training.

I understand that I must supply the medication in the original container, dispensed and properly labeled by an authorized prescriber, dentist, or pharmacist. Over the counter medication must be in the original container labeled with the child's name.

I understand that this medication will be stored in a secure location, by camp health care personnel, and will be returned to the child and/or parent at check-out, on the final day of camp.

Name of parent/guardian _____ Signature _____
Print name

Relationship to child _____ Phone # (____) _____

Address _____ city _____ state _____

Medical History Information Form

Note: This information will be kept confidential.

Name of camper _____ date of birth _____

Home address _____

_____ city _____ state _____ zip _____

Parent's e-mail: _____

Primary emergency contact: _____ relation _____

Home phone _____ work # _____ cell# _____
(ac) (ac) (ac)

Secondary contact: _____ relation _____

Home phone _____ work # _____ cell # _____
(ac) (ac) (ac)

Physician name _____ phone _____
(ac)

Dentist name _____ phone _____
(ac)

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Medical Insurance – it is recommended that you give your child a copy of the medical insurance card.

Name of insurance company _____

Policy # _____ Group # _____

Insured name _____

Phone number on back of insurance card _____

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Medical History

Date of camper's most recent physical _____

* **NOTE: Athlete MUST provide copy a current physical** (dated within 3 years of start of camp).

Does the camper have any of the following **medical conditions**? (please circle "yes" or "no")

Asthma yes no medications: _____

Cardiac (heart) condition yes no medications: _____

Diabetes yes no medications: _____

Epilepsy/seizure disorder yes no medications: _____

ADHD/ADD yes no medications: _____

OTHER yes no list: _____

Is the camper allergic to?

medications yes no list: _____

