**YOUTH CAMP HEALTH EXAM/RECORD**
Physical Exams are Valid for 3 Years from Date of Last Examination PLEASE RETURN COMPLETED FORM TO:
Bulldog Golf Experience, LLC
17 Briar Lane, Hamden, CT 06517

SESSION ATTENDING: _____

Name _____DOB_____ Phone _____

Guardian _____

Address _____

Emergency contact _____Phone(s) _____

TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER:

Date of Exam_____
_____ May participate in all camp activities
_____ May participate except for: _____
_____

Medical information pertinent to routine care and emergencies:

_____
_____
Is this individual taking prescription medication? YES NO
If YES, indicate prescription: _____
Does the individual have allergies? YES NO Explain: _____

This camper is up-to-date on all the following routine immunizations recommended by the American Academy of Pediatrics and National Advisory Committee on Immunization Practices:

| | | | | | |
|---|---|---|---|---|---|
| Measles | YES | NO | Hepatitis B | YES | NO |
| Mumps | YES | NO | Diphtheria | YES | NO |
| Rubella | YES | NO | Pertussis | YES | NO |
| Chickenpox | YES | NO | Polio | YES | NO |
| Tetanus | YES | NO | | | |

NAME OF INSURANCE CARRIER: _____

GROUP OR POLICY NUMBER: _____
Yale University insurance policy requires that a camper's family health insurance plan be responsible for any medically related services provided to their child. The camper's complete medical form must include the family's insurance provider and current policy number.

NAME OF FAMILY PHYSICIAN: _____
TELEPHONE: _____

ASSUMPTION OF RISK AND PERMISSION FOR TREATMENT – MUST BE COMPLETED BEFORE ATTENDING CAMP. Parental authorization: The health history is correct as far as I know, and the person herein described has permission to engage in all prescribed camp activities noted by me and examining physician. Permission is hereby granted for medical and surgical care and treatment to be provided by medical personnel at Yale University Health Services or Yale-New Haven Hospital. Should a medical emergency arise during a field trip, permission is granted to obtain treatment at a nearby hospital. I also understand that participation in sports activities can result in injury and that I will not hold the camp, staff, or Yale University responsible should any event occur unless negligence has occurred.

SIGNATURE OF PARENT/GUARDIAN: _____DATE _____

SIGNATURE of Physician, APRN, or PA: _____ DATE _____

**Authorization for Self Administration of Medication by Camper**

The Bulldog Swimming Camp does not dispense any medications to campers. Campers who need to take prescription or over the counter medication must come to camp with authorization of self-administration of medication from both the parents and a physician.

Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and the date of the prescription. All medications must be given to the head camp counselor who will keep them in a locked box in his or her room. Campers must come to the head counselor to access their medications. All unused medication will 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 _____

Medication Administration: Start Date ___/___/___ Stop Date ___/___/___

Relevant Side Effects of Medication _____

Plan of Management for Side Effects _____

Known Food or Drug: Allergies ___Yes ___ No Reactions to ___Yes ___ No

If "yes" to any of the above, please explain _____

Prescriber's Name _____ Phone Number ( ) _____

Prescriber's Address _____ Town _____

Prescriber's Signature _____

Authorization for self-administration of medication:

I authorize _____ to self-administer medication. The camper has been taught proper administration of this medication.

Prescriber's Signature _____

**Parent/Guardian Authorization for Self Administration of Medication:**

I request that my child can self medicate as described and directed above.

Name of Camp _____ Today's Date ___/___/___

Child's Name _____Address _____ Town _____

Name of Parent/Guardian Authorizing self administration of medication _____

Relationship to Child: Mother ___ Father ___ Guardian/Other explain:_____

Address _____Town _____Phone _____

Signature of Parent/Guardian Authorizing Self Administration of Medication: _____

**Name of Camp Personnel Receiving Written Authorization and Medication:** _____

Title/Position _____ Signature (in ink) _____