CAMPUS REC

Boston College Recreational Day Camp
2020 Required Camper Paperwork

Name of Camper: _____

Required Forms:

- ☐ Medication & Emergency Treatment Authorization
  - If your child is not taking any medications, please write N/A in the space provided
  - Please attach a copy or your child's insurance card (front and back)
- ☐ Camper Pick-Up Form
  - Only individuals on this form will be permitted to pick up your child
- ☐ Physical Examination Form
  - The physical must have been conducted during the preceding 12 months
  - A Physician's Signature is required
- ☐ Immunization Record
- ☐ Sunscreen Permission Form

****All forms are due four weeks prior to the start of the first camp session(s) your child is registered for. Paperwork can be submitted via:**

E-mail: bcreccamp@bc.edu (preferred method)

Fax: 617-552-1886

Mail or Hand Delivered:
Margot Connell Recreation Center
ATTN: Rec Camp
140 Commonwealth Ave Chestnut
Hill, MA 02467

BOSTON COLLEGE

Medication & Emergency Treatment Authorization
For Participants in Programs Involving Minors

This form must be completed by a parent or legal guardian prior to participation in any youth program sponsored by Boston College.

I. General Information Concerning Child

Name of Child: _____ **Date of Birth:** ____/____/_____
(Print Last, First, Middle) (MM/DD/YYYY)

Address: _____

_____

M or F (circle one)

Name of Boston College Program (the "Program") in which child will participate:

_____

II. Parent or Guardian Information:

Name of Responsible Parent/Guardian: _____
(Print Last, First, Middle)

Home Address (if different): _____

_____

Work address: _____

_____

Home Phone: (_____) ____ - _____ Business Phone: (_____) ____ - _____

Mobile Phone: (____) ____ - _____

III. Emergency Contact Information:

Name of Emergency Contact: _____
(Print Last, First, Middle)

Relation to Child: _____

Home Address: _____

_____

Work address: _____

_____

Home Phone: (_____) ____ - _____ Business Phone: (_____) ____ - _____

Mobile Phone: (____) ____ - _____

IV. Health Insurance Information:

Health Insurance Company: _____

Policy Identification Number: _____

PLEASE ATTACH PHOTOCOPY OF INSURANCE CARD (BOTH SIDES)

V. Health Information

A. Allergies. Is your child allergic to any of the following?

Medications: Yes/No (circle): If yes please explain: _____
_____
_____

Food: Yes/No (circle): If yes please explain: _____
_____
_____

Insect Bites: Yes/No (circle): If yes please explain: _____
_____
_____

B. Medications:
Please List all medications your child is currently taking, including epi-pen, inhaler or insulin injection (add separate sheet if needed. If your child is not on medication, please write N/A below.):

Medication	Dose	Frequency	Reason
1._____	_____	_____	_____
2._____	_____	_____	_____
3._____	_____	_____	_____

PLEASE NOTE: The Program staff prefers whenever possible that medication be administered outside of Program hours, under the supervision of a parent or guardian. If medications need to be administered during program hours, please sign the appropriate authorization below:

☐ **I hereby authorize Program staff to administer to my child the following medication(s): _____. I understand that medications must be delivered to the program staff in original containers bearing the name of my child, the prescribing doctor, directions for use, and showing the number of tablets or capsules, as appropriate. No medication will be accepted in bags separate from the original container. I acknowledge that the medication will be administered by a supervisor who is not a licensed health care professional.**

Name of Parent or Guardian: _____
(Print Last, First, Middle)

Signature: _____

Date: _____

☐ **I hereby authorize my child to self-administer his or her epi-pen, inhaler, or insulin when he or she requires it during program hours.**

Name of Parent or Guardian: _____
(Print Last, First, Middle)

Signature: _____

Date: _____

C. History:
Please list all significant past or current medical surgical or mental health conditions, including hospitalizations:

VI. Consent and Release

I understand that participation by my child in the Boston College program named above involves a certain degree of risk. I also understand that participation in the Program is entirely voluntary and requires participants to abide by applicable rules and standards of conduct.

In case of an emergency involving my child, I understand that effort will be made to contact me or the individual listed as the emergency contact person.

In the event that neither me nor the emergency contact person can be reached, permission is hereby given to the medical provider selected by those in charge of the Program to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child.

Medical providers are authorized to disclose protected health information to the supervisors of the Program, and/or any physician or health care provider involved in providing medical care to my child, including examination findings, test results, and treatment provided for purposes of medical evaluation of the participant, follow-up and communication with the me, and/or determination of my child's ability to continue in the Program activities.

I have carefully considered the risk involved and give consent for my child to participate in these activities. I approve the sharing of the information on this form with program administrators and professionals who need to know of medical situations that might require special consideration for the safety of my child.

I release the Boston College, its employees and volunteers, including, without limitation, those persons having responsibility for the Program from any and all claims or liability arising out of this participation.

Signature of Parent or Guardian: _____

Name: _____
(Print Last, First, Middle)

Date: _____

Camper Pick-Up Authorization
Boston College Recreational Day Camp 2020

Mandated by Massachusetts State Law 105 CMR 430.159(B), please provide a list of the individuals who will be authorized to pick-up the named camper. No camper will be released to an individual who is not listed on this form.

Camper's Name (please print):_____

Parent/Guardian #1: Name:_____Signature:_____

Phone #:_____Email:_____

Parent/Guardian #2: Name:_____Signature:_____

Phone #:_____Email:_____

Other Authorized Individuals:

1. Name _____Phone #_____ Relationship to Camper_____
2. Name _____Phone #_____ Relationship to Camper_____
3. Name _____Phone #_____ Relationship to Camper_____

Individuals NOT Authorized to pick up the named camper (please print):

1. _____
2. _____
3. _____

***If there is last minute change and an individual not listed below will be picking up the camper, written authorization must be provided at morning drop-off or e-mailed by noon to bcreccamp@bc.edu.**

Physical Examination/Medical History Form Boston College Recreational Day Camp 2020

Please Complete BOTH Sides of Form
Please Print

FORM WILL NOT BE ACCEPTED WITHOUT PHYSICIAN'S SIGNATURE

LAST NAME: _____ **FIRST NAME:** _____

DATE OF BIRTH: _____/_____/_____ **AGE:**_____ **SEX:** _____

HOME ADDRESS: _____

CITY: _____**STATE**_____**ZIP CODE**_____

PARENT/GUARDIAN 1:_____**RELATION:**_____

HOME PHONE: (_____) _____ **WORK PHONE:** (_____) _____
CELL PHONE: (_____) _____

PARENT/GUARDIAN 2:_____**RELATION:**_____

HOME PHONE: (_____) _____ **WORK PHONE:** (_____) _____
CELL PHONE: (_____) _____

HEALTH HISTORY
Please fill in dates where appropriate.

Illness		*****Allergies**		**Disease**	
Frequent Ear Infections	_____	Hay Fever	_____	Chicken Pox	_____
Heart Defect/Disease	_____	Ivy Poisoning	_____	Measles	_____
Convulsions	_____	*Insect Stings	_____	German Measles	_____
Diabetes	_____	Medicine	_____	Mumps	_____
Bleeding/Clotting Disorders	_____	Foods	_____		
**Asthma	_____	*What Insects	_____		

**Please describe care necessary to handle asthma (i.e.-use of inhaler) _____
***If Epi-Pen is required to handle allergic reaction, family must supply one.

Operations or serious injuries (with dates):_____
Chronic or recurring illness:_____
Any specific activities to be restricted?_____
Name of Campers Dentist?_____Phone_____
Name of Campers Doctor?_____Phone_____
Name of Medical InsuranceCarrier: _____**Policy#**_____
Address:_____**Phone**_____

PARENT/GUARDIAN AUTHORIZATION: MUST BE SIGNED FOR CHILD TO PARTICIPATE IN CAMP
This Health History is correct so far as I know, and the child described herein has permission to engage in all prescribed program activities except as noted by the examining physician and me. I hereby, authorize the staff of Boston College to provide care that includes routine diagnostic procedures (i.e.-x-rays, blood and urine test) and medical treatment to my minor camper. I understand that the consent and authorization herein granted does not include major surgical procedures and are valid only during camp.

Parent/Guardian Signature: _____Date:_____

Print Name: _____

IMMUNIZATION HISTORY AND DATES

DPT 1._____ **2.**_____ **3.**_____ **4.**_____ **(Td)*5.**_____	**Polio 1.**_____ **2.**_____ **3.**_____ **4.**_____	**MMR (combined)** **1.**_____ **2.**_____	**Meningococcal** **(not required)** **1.**_____
History of Chicken Pox **Yes**_____ **Date**_____ **No**_____	**HIB 1.**_____ **2.**_____ 3._____ **4.**_____	**Hepatitis B Series** **(**only for children born on or after 1/1/92) **1.**_____ **2.**_____ **3.**_____	

*Td Booster Required for children of age 12 or older.

Medical Examination

- To be filled in by a licensed physician.
- This examination should be performed within one calendar year of arrival at the Boston College Camp.
- Examination for some other purpose within this period is acceptable

Code: V-Satisfactory
X-Not Satisfactory (explain)
O-Not Examined

Ht._____ Wt._____ Blood Pressure_____

Eyes_____ Lungs_____ Urinalysis_____

Allergy_____ Please describe degree of allergic reaction:_____

Glasses_____ Contacts_____ Abdomen_____

Ears_____ Hernia_____ Head (Concussion)_____
Nose_____ Genitalia_____ Extremities_____
Throat_____ Posture (spine)_____ General Appraisal_____
Heart_____ Cardiovascular Disease_____ Skin_____

Current Medications_____
Special Diet_____
Musculoskeletal Injuries (explain)_____
Any Specific activities to be restricted?_____

I have examined the person described herein and have reviewed the health history. It is my opinion that this person is physically able to engage in program activities, except as noted above.

Examining Physician:_____ Date:_____
Please Print Physician's Name_____
Address:_____ Phone_____

Sunscreen Permission Form

Due to the Massachusetts Health Department's guidelines, all campers MUST have the following permission slip signed and dated by a parent or guardian.

The Boston College Recreational Day Camp requests that sunscreen be applied to your child prior to them attending camp for the day. However, with the permission of a parent/guardian, the Boston College Recreational Day Camp staff can apply and/or assist your child in the application of sunscreen as needed throughout the camp day. Please complete the form and sign below if you would like the Boston College Recreational Day Camp staff to apply or assist your child in applying sunscreen throughout the camp day.

I _____ give permission to the Boston College

Recreational Day Camp staff to apply and/or assist in the application of sunscreen to my child

_____ as needed during the camp day.

Parent/Guardian Signature: _____

Date: _____