



P.O. Box 664, 65 Main Street
North Grosvenordale, CT 06255
Phone (860) 923-3458 Fax 860-923-5770
email loribteeg@yahoo.com

All-Star Adventure Program

Summer 2010

Child's Name: _____ Gender: M F
First Name Last Name please circle one

Date of Birth: ____/____/____ Age: ____ Ethnicity: _____

Parent/Guardian: First Name: _____ Last Name: _____

Address: _____

City: _____, CT Zip Code: _____ Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Referral Source: _____ Agency: _____ Phone: _____

Reason for Referral: _____

2010 Program Information

- ☛ Program will be held three days a week between the dates of July 5 and August 13
- ☛ Cost for each session is \$2700 per child and is inclusive of transportation, lunch and all admission fees
- ☛ Transportation will be provided daily, pick-up will take place between 7:45 a.m. and 8:30 a.m. and drop-off will be between 2:30 p.m. and 3:30 p.m.

Applicants will be reviewed upon referral and be accepted following a brief family interview. All applicants will be notified of acceptance into the program no later than one week prior to the start of each session.

HEALTH HISTORY

Child's Name: _____

ALLERGIES TO MEDICATIONS: None / List all: _____

FOOD ALLERGIES: None / List all: _____

- | | | | | |
|--|--|---|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Asthma | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Bed Wetter | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> Convulsions/Seizures | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Behavior Problems | <input type="checkbox"/> Learning Disabilities | | | |

Details of Conditions Checked Above:

Operations or serious injuries (give dates):

Chronic or recurring illnesses:

Other diseases/conditions:

Does the camper see a behavior management doctor, psychiatrist, psychologist or therapist? YES NO

If yes, please give name and phone number:

Parent/Guardian Authorization:

I affirm that this health history is correct and that the child has permission to engage in all program activities, except as noted by me or the physician. I hereby give consent to the release of medical information about my child to the staff to the extent necessary. *I give the staff permission to provide routine healthcare and seek emergency medical treatment when necessary.*

Parent/Guardian Signature: _____ Date: _____

SUMMER 2010

Child's Name: _____

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

To be filled out by the child's physician or dentist

(Please disregard this page if no medications are being taken on a routine basis)

Parents/Guardians requesting medication administration to their child from staff 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 OR DENTISTS' ORDER (Physician, Dentist, Physician Assistant, Advanced Practice Registered Nurse):

Name of Child _____ **Date of Birth** _____

Today's Date _____

Known Food or Drug: Allergies Yes No **Reactions to?** Yes No **Interactions with?** Yes No

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

	<u>Prescription #1</u>	Prescription #2
Medication Name		
Dosage		
Method		
Time of Administration		
Controlled Drug?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Specific Instructions for Medication Administration		
Relevant Side Effect of Medication		
Plan of Management for Side Effects		

Over-the-Counter Medications -- Permission for the following over the counter medications to be administered to applicant if deemed necessary by the staff. Please note that the name brand or its generic equivalent may be used. Dosages will be administered according to the directions on the original container unless a physician directs otherwise. **Please cross out any medications that are not to be administered.** If preferred, alternate over-the-counter medications may be sent with the child. All medications must be sent in the original containers with the dosage instructions provided.

Condition Treated

Medication Used

- | | |
|-------------------|---|
| Burns | Burn Gel, Burn Cream |
| Chapped/Dry Lips | Chapstick, Vaseline |
| Dry Eyes | Moisturizing eye drops, saline solution |
| Emergency Allergy | Epipen, Benadryl |
| Eye Wash | Saline Solution, Eye Wash |
| Headache | Tylenol, Ibuprofen |
| Insect bite | Medicaine, Afterbite, Afterbite Jr. |

SUMMER 2010

Over the Counter Medications (continued)

Child's Name: _____

Poison Ivy	Caladryl, calagel, calamine lotion
Rash	Hydrocortisone cream, benadryl cream
Seasonal allergies	Sudafed, Benadryl
Skin Break	Bacitracin, triple antibiotic cream/ointment, antiseptic, isopropyl alcohol, hydrogen peroxide
Sore throat	Throat lozenge
Other	Bug Repellent, Sunscreen

AUTHORIZATION FOR ADMINISTRATION OF THE ABOVE MEDICATION/S

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

Name of Parent/Guardian Authorizing Administration of Medication _____

Relationship to child: Mother Father Guardian/Other explain _____

Address _____

Phone Number _____ Alternate Number: _____

Signature of Parent/Guardian

Date

SUMMER 2010 Child's Name: _____
PHYSICIAN'S FORM

To be filled out by the child's physician or dentist

IMMUNIZATION HISTORY: Include all dates of basic immunizations and most recent boosters.
 (A vaccination history record may be attached, but must include all information)

DPT	1 st	2 nd	3 rd	Tetanus Booster
Oral Polio	1 st	2 nd	3 rd	Booster
HEP B	1 st	2 nd	3 rd	Booster
MEASLES VACCINE/MMR (LIVE)	1 st	2 nd	Booster	PPD Dare (Optional)
Other	Date	Other	Date	Other

PHYSICAL EXAMINATION

	Satisfactory	Not Satisfactory	Not Examined	Details
HEENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Posture / Spine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Metabolic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Additional Health Information: _____

Applicant is under the care of physician for the following conditions: _____

Regularly Taken Medications: _____

General Appraisal of Patient: _____

Restrictions for the program: None Other: _____

I have examined the person herein described and reviewed the health history. It is my opinion that this child is physically able to participate in the ALL-STAR Adventure Program activities except as noted above. I attest that this child has had a physical within the last 2 years.

Last Exam Date: ____/____/____ (Must be within 2 years of camp)

Prescriber's Name: _____ License #: _____

Prescriber's Address _____ ity, State: _____

Phone: _____ Fax: _____

PRESCRIBER'S SIGNATURE: _____ **Date**