The Barn Health Exam/Record

Physical Exams are Valid for 3 Years From Date of Last Examination

Name _____Date of Birth _____ Address _____ Emergency Contact_____ Phone_____

Relationship to Camper _____ Alternate Phone _____

……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 or over the counter medication(s)? YES NO If yes, indicate names of medication(s):_____ Does the individual have allergies? YES NO Explain:_____

Is the individual on a special diet? YES NO Explain:_____

Does the individual have special needs? YES NO Explain:_____

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

	YES	**NO**		**YES**	**NO**
Measles			Pertussis		
Hepatitis			Chickenpox		
Mumps			Polio		
Diphtheria			Tetanus		
Tetanus			Rubella		

Comments:_____

_____

Print name of medical care provider:_____

Medical care provider's address: _____

Medical care provider's: City/Town_____ State____ Zip Code_____

Medical care provider's Number_____

_____ _____

Signature of Physician, PA, APRN,RN Date form signed

Authorization for the Self-Administration of Medication While Attending Programs at the Madison Arts Barn

Parent/guardians requesting to be self-administered by their child while at camp shall provide the program with appropriate written authorization and the medication before any medications are administered. Medications must be in the original container and labeled with the child's name, name or medication, directions for medication's administration and date of the prescription. 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 _____ Specific Instructions for Medication Self-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 /interactions with? Yes No

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

Prescriber's Name _____ Phone Number _____

Prescriber's Address _____ Town _____ ST _____

Prescriber's Signature _____

Parent/Guardian Authorization:

I request that medication be self-administered by my child 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)_____