SLA Youth Programs Medical and Legal Form

We strive to make SLA a safe place for our campers. One way we do that is by having you complete a health history for your child so that we may be better prepared in the event of an emergency. The health form is kept confidential and used by our camp staff (or emergency medical personnel). Every camper/sailor needs a completed health form to participate in SLA summer camp programs.

Please fill out this form as completely as possible. Campers are not singled out, made to feel embarrassed or treated differently because of information gathered from the health form. Rather, the more we know ahead of time, the easier it is to help your child have a successful experience at camp.

Forms must be received before the start of camp. Send forms to: 534 US Route 3, Holderness, NH 03245 or Fax to 603-968-7444 or Drop off at the Main Office.

You must include a record of a physical examination dated within two years of first day of camp.

Thank you!

________________________________________________________________________________
Camper Name ________________________

 LAST                      FIRST                      MIDDLE

Group:  Week: (circle all that apply)

☐ Discovery (Grades 3 & 4)          Week 1           Week 5
☐ Explorer (Grades 5 & 6)           Week 2           Week 6
☐ Expedition (Grades 7, 8, & 9)     Week 3           Week 7
☐ Leader in Training (Grades 10+)   Week 4
☐ CYSP Sailing

Please be sure to turn in all of the necessary forms:

☐ Medical and Legal Forms
☐ Record of Physical Examination
☐ Immunization Records
☐ Religious Exemption Form (if necessary)

Call 603-968-7336 with any questions!
SECTION I – BASIC CONTACT INFORMATION

Camper Name ___________________________________________ 

Birth date _____/_____/____ Age ______

Home Address ___________________________________________

Home Phone _____________________________

Gender: ☐ Male ☐ Female ☐ Non-binary ☐ Prefer to self-describe __________________________

Camper Lives With: ☐ Parent #1 & 2 ☐ Parent #1 ☐ Parent #2 ☐ Grandparent ☐ Other:

Parent/Guardian #1 Name _________________________________________

Phone: ________________________________

Email: ________________________________

Parent/Guardian #2 Name _________________________________________

Phone: ________________________________

Email: ________________________________

Additional Emergency Contact ___________________________ Relationship____________________

(In case we can’t reach you)

Phone: ________________________________

Family Physician Name ___________________________ Phone ________________________________

Dentist/Orthodontist Name ___________________________ Phone ________________________________

SECTION II – INSURANCE INFORMATION

Is the camper covered by family medical/hospital insurance? ☐ Yes ☐ No

If yes, indicate Insurance Carrier ___________________________ Group or Policy # ___________________________

Policy Holder’s Name ___________________________ Relationship to participant ___________________________

Policy Holder’s Insurance ID # ___________________________
SECION III – MEDICATIONS

MEDICATIONS – Please note that campers MUST be able to self-administer all medications that may be necessary during the camp week.

Will camper be taking medications while at camp?  ☐ Yes  ☐ No
(Medications include prescription, over-the-counter, vitamins, inhalers, etc.)

If no, continue to next page.

If yes, please list all (prescription and non-prescription). Include the medication name, prescribing physician, physicians' phone number, and the dosage instructions. Use an additional sheet if needed. When you check in at camp, please provide all medications in their original packaging that identifies the prescribing physician (if prescription drug), the name of the medication, the dosage, and frequency of administration. Campers MUST be able to self-administer medications.

Medication_____________ Dosage_____________ Take at what times_____________
Reason for taking_____________________________________________________________
Prescribing physician_________________________________ Phone____________________

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Reason for taking_____________________________________________________________
Prescribing physician_________________________________ Phone____________________

Medication_____________ Dosage_____________ Take at what times_____________
Reason for taking_____________________________________________________________
Prescribing physician_________________________________ Phone____________________
SECTION IV – ALLERGIES

ALLERGIES

☐ Camper does not have any allergies

Camper is allergic to

☐ 6. Other Drugs ☐ 7. Other


__________________________________________________________________________

__________________________________________________________________________

POSSESSION AND USE: EPINEPHRINE AUTO-INJECTOR OR ASTHMA INHALER

☐ Child DOES NOT possess or use an epinephrine auto-injector or asthma inhaler. Continue to next section.

☐ Child DOES possess or use an epinephrine auto-injector or asthma inhaler. Please fill out this form.

Child’s Name: ________________________________ Child’s Date of Birth: ______________________
Camp Attendance Dates: ______________________

Name of Medication: __________________________ Route of Medication: ______________________
Dosage of Medication: _________________________
Frequency & Time of Medication Assistance: _________________________
Date of Order: ______________________________

Name of each required medication: __________________________________________

__________________________________________________________________________

Specific recommendations for administration: ____________________________________

__________________________________________________________________________

Any special side effects, contraindications or adverse reactions to be observed: _________________

__________________________________________________________________________

I/we certify that the child may possess and use an asthma inhaler or epinephrine auto-injector (circle one) at any camp sponsored event, activity or program and I/we certify that the child has the knowledge and skills to safely possess and use an asthma inhaler or epinephrine auto-injector (circle one) in a camp setting:

Name of Licensed Prescriber: __________________________ Date: ______________________
Signature: __________________________________________
Business Telephone: ________________________________
Emergency Telephone: ______________________________

Name of Parent or Guardian: __________________________ Date: ______________________
Signature: _________________________________________
Business/Daytime Telephone: _________________________
Emergency Telephone: ______________________________
SECTION V – HEALTH HISTORY

Please know that we value your privacy. Health History information is available only to JSLA and CYSP camp staff. This knowledge is helpful in providing your child with a more successful camp experience. The more information you provide, the better we can do our job. Thanks!

Has the camper had a history of or is prone to any of the following (Please check all that apply).

| ☐ Recent injury, illness or infectious disease | ☐ Chronic or recurring illness | ☐ Asthma |
| ☐ Homesickness | ☐ History of Bedwetting | ☐ Sleepwalks |
| ☐ Nightmares / Night Terrors | ☐ Frequent Ear Infections | ☐ Seizure Disorder or Convulsions |
| ☐ Dizziness during or after exercise | ☐ Chest pain during or after exercise | ☐ Heart Defect/Disease |
| ☐ Hypertension | ☐ Bleeding/Clotting Disorders | ☐ Diabetes |
| ☐ Mononucleosis (in last 12 months) | ☐ Chicken Pox | ☐ Measles |
| ☐ German Measles | ☐ Mumps | ☐ Tuberculosis |
| ☐ Hepatitis | ☐ Joint problems (knees, ankles) | ☐ Fractures |
| ☐ Frequent Headaches | ☐ Head Injury | ☐ Psychiatric Treatment |
| ☐ Eating Disorder | ☐ Diarrhea or constipation | ☐ Frequent Stomachaches |
| ☐ Wears glasses or contacts | ☐ Been Hospitalized | ☐ Wears a Medic Alert ID |

Please provide an explanation for all checked items

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

SECTION VI – IMMUNIZATIONS

You must attach a complete immunization form from your child’s physician (or fax to 603-968-7444). If your child has not received the proper immunization for measles, hepatitis B, mumps, rubella, polio, tetanus, and/or diphtheria, you must include a New Hampshire Religious Exemption form.

SECTION VII – PHYSICIAN’S CERTIFICATION (You may include a record of physical, dated within two years of camp, in lieu of this section.)

I certify that _________________________ has received a physical examination within two years prior to entrance to camp. Any conditions that would preclude or limit this child’s participation in summer camp are listed below.

Conditions that would preclude or limit this child’s participation in summer camp:

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Physician’s signature: ________________________________            Date: ____________

Physician’s name: ________________________________

Physician’s phone: ________________________________
SECTION VIII – OTHER IMPORTANT INFORMATION:

Special dietary needs:
____________________________________________________________________________________
____________________________________________________________________________________

Physical activities to be limited or restricted while at camp:
____________________________________________________________________________________
____________________________________________________________________________________

If your child has any exceptional behavioral, emotional, learning and/or physical needs, it is helpful to have as much honest and forthright information about them as possible. Please share with us any circumstances that might affect your child's participation in our youth program activities and their interaction with other campers and staff.
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Anything else you'd like to share with us?
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

SECTION IX – AUTHORIZATION FOR PICK-UP AND DROP-OFF

The following individuals are authorized to pick-up and drop-off this camper.

1. Name_____________________________ Relationship to camper________________
   Phone_____________________________

2. Name_____________________________ Relationship to camper________________
   Phone_____________________________

3. Name_____________________________ Relationship to camper________________
   Phone_____________________________

4. Name_____________________________ Relationship to camper________________
   Phone_____________________________
SECTION X – AUTHORIZATION

CHILD’S NAME: ____________________________ Group Name & Week_____________________

PERMISSION AND INDEMNITY

I give permission for my child, named above, to participate in any and all Squam Lakes Association youth program activities, including day trips and overnights. I understand that these activities will include automobile travel, boating, hiking, sailing, swimming, team sports, climbing wall, rock climbing and other activities which create some risk of injury.

In consideration of the opportunity for my child to participate in youth program activities, I, for myself and on behalf of my child, release the Squam Lakes Association, its employees, volunteers, directors and officers, and the owners and operators of vehicles and water craft and the owners and lessees of land where youth program activities occur, from all liability for any personal injury, bodily injury, property damage, and loss of any kind (including attorney’s fees) occurring to my child in connection with my child’s participation in youth program activities. I also agree to indemnify the same persons and organizations from all liability for any personal injury, bodily injury, property damage, and loss of any kind (including attorney’s fees) caused to anyone by my child.

Please initial: _________

AUTHORIZATION FOR EMERGENCY HOSPITALIZATION AND SURGERY

I give permission for such diagnostic, therapeutic and operative procedures to be performed by a duly licensed physician or surgeon as the said doctor shall have deemed necessary for my child, named above, with the understanding that no operation will be performed except in extreme emergency without a reasonable effort on the part of the Squam Lakes Association to contact the responsible parent or guardian by telephone or other expedient means.

Please initial: _________

PARENT/ GUARDIAN ASSUMPTION OF RESPONSIBILITY

I hereby certify that my child, named above, has no limitations which would preclude his/her participation in the Squam Lakes Association youth program activities.

Please initial: _________

MEDIA RELEASE

I authorize and consent to the use of photos / videos taken of my child without present or future compensation in newspapers, newsletters, and the website or in other ways to inform the public about the Squam Lakes Association.

Please initial: _________

I do not give consent – Please initial: _________

________________________________________  __________________________
Parent/Guardian Signature                  Date

________________________________________
Parent/Guardian (Print name)