SQUAM LAKES ASSOCIATION

For Office Use Only:

Reviewed by:_____
Date:_____
Notes:

Further approval required: ☐YES ☐NO
Reason:_____

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: POB 204, 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:

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

Week: (circle all that apply)

Week 1 Week 5
Week 2 Week 6
Week 3 Week 7
Week 4

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 _____
LAST FIRST MIDDLE

Birth date _____/_____/ _____Age _____

Home Address_____
STREET CITY STATE ZIP

Home Phone_____

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

Camper Lives With: ☐Mother & Father ☐Mother ☐Father ☐Grandparent ☐Other:

Mother/Guardian #1 Name_____

Phone: _____

Email: _____

Father/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 #_____

SECTION 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 Benadryl Administration at bottom of this 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_____

Medication_____Dosage_____Take at what times_____

Reason for taking_____

Prescribing physician_____Phone_____

Medication_____Dosage_____Take at what times_____

Reason for taking_____

Prescribing physician_____Phone_____

Benadryl Administration: In case a child has an undiagnosed allergy and experiences an allergic reaction that is severe our staff carries Diphenhydramine (Benadryl) to help reduce symptoms until Emergency personnel arrives.

By signing below, I give permission for **trained** camp staff to administer Diphenhydramine (Benadryl) during the event that the camper experiences a severe allergic reaction at camp.

Parent/Guardian Signature: _____

Date: _____

☐ Camper is allergic to Benadryl **DO NOT** use.

SECTION IV – ALLERGIES

ALLERGIES

☐Camper does not have any allergies

Camper is allergic to

☐1. Hay Fever ☐2. Poison Ivy/Oak ☐3. Insect Stings ☐4. Food ☐5. Penicillin
☐6. Other Drugs ☐7. Other

List allergy. Describe reaction and treatment.
_____
_____
_____

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 IMPORANT 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)