

Troop 102

Instructions for Summer Camp Med Forms and Permission Slip 2020

Tip 1:

Please review this instruction packet prior to completing the medication forms and permission slip. Many common mistakes can be avoided. This can prevent repeat trips to the doctor's office and reduce last minute stress.

Tip 2:

Start early, you never have as much time as you think you do. Summer will be here before you know it. It is almost Spring.

Tip 3:

Please use the **Summer Camp Permission Slip** not the standard Troop Permission Slip used for weekend campouts.

Tip 4:

If for insurance reasons you can't schedule a physical till near the deadline, RELAX. Just let me know you will be late so I don't have to chase you down.

Tip 5:

If your Scout is going on the High Adventure trip in addition to Summer Camp, you will need to submit two copies of the med forms. The forms go to the camps, so one copy will not be sufficient.

Tip 6:

If you are unsure about something, don't guess. Email me or call if you have a question.

Happy Camping!

Scouts Name
And DoB

Ignore this box on all pages, summer camp is not considered "High Adventure". If your Scout is going on the High Adventure trip, the leader will complete this section.

Part A: Informed Consent, Release Agreement, and Authorization

A

Full name: _____ High-adventure base participants: _____
 Expedition/zone No.: _____
 Date of birth: _____ or staff position: _____

Informed Consent, Release Agreement, and Authorization

I understand that participation in Scouting activities involves the risk of personal injury, including death, due to the physical, mental, and emotional challenges in the activities offered. Information about these activities may be obtained from the news, activity coordinator, or your local council. I have understood that participation in these activities is entirely voluntary and require participants to follow instructions and abide by all applicable rules and the standards of conduct.

I also hereby assign and grant to the local council and the Boy Scouts of America, as well as their authorized representatives, the right and permission to use and publish the photographs/film/videotapes/electronic representations and/or sound recordings made of me or my child at all Scouting activities, and I hereby release the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with the activity from any and all liability from such use and publication. I further authorize the reproduction, sale, copyright, exhibit, broadcast, electronic storage, and/or distribution of said photographs/film/videotapes/electronic representations and/or sound recordings without limitation of the discretion of the BSA, and I specifically waive any right to any compensation I may have for any of the foregoing.

In case of an emergency involving me or my child, I understand that efforts will be made to contact the individual listed as the emergency contact person by the medical provider and/or adult leader. In the event that this person cannot be reached, permission is hereby given to the medical provider selected by the adult leader in charge to access proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for me or my child. Medical providers are authorized to disclose protected health information to the adult in charge, camp medical staff, camp management, and/or any physician or health-care provider involved in providing medical care to the participant. Protected Health Information/Confidential Health Information (PHI/CHI) under the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. §§160.102, 164.501, etc. may, as assessed from time to time, include examination findings, test results, and treatment provided for purposes of medical evaluation of the participant, follow up and communication with the participant's parents or guardians, and/or determination of the participant's ability to continue in the program activities.

Every person who handles any DD device in any manner, without the express or implied permission of the parent or legal guardian of the minor, is guilty of a misdemeanor. (California Penal Code Section 26102.5) My signature below on this form indicates my consent.

I give permission for my child to use a DD device. (Note: Not all events will include DD devices.)
 Checking this box indicates you DO NOT want your child to use a DD device.

NOTE: Due to the nature of programs and activities, the Boy Scouts of America and local councils cannot continuously monitor compliance of program participants or any limitations imposed upon them by parents or medical providers. However, so that leaders can be as familiar as possible with any limitations, list any restrictions imposed on a child participant in connection with programs or activities below.

List participant restrictions, if any: None

(If applicable) I have carefully considered the risk involved and hereby give my informed consent for my child to participate in all activities offered in the program. I further authorize the sharing of the information on this form with any USA volunteers or professionals who need to know of medical conditions that may require special consideration in conducting Scouting activities.

With appreciation of the dangers and risks associated with programs and activities, on my own behalf and/or on behalf of my child, I hereby fully and completely release and waive any and all claims for personal injury, death, or loss that may arise against the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with any program or activity.

I understand that, if any information I have provided is found to be inaccurate, it may limit and/or eliminate the opportunity for participation in any event or activity. If I am participating at Philmont Scout Ranch, Philmont Training Center, Northern Tier, Sea Base, or the General Jackel Boaters, I have also read and understood the supplemental risk advisories, including height and weight requirements and restrictions, and understand that the participant will not be allowed to participate in applicable high-adventure programs if those requirements are not met. The participant has permission to engage in all high-adventure activities described, except as specifically noted by me or the health-care provider. If the participant is under the age of 18, a parent or guardian's signature is required.

Participant's signature: _____ Date: _____
 Parent/guardian signature for youth: _____
 (If participant is under the age of 18)

This can be ignored, it applies only to California

List any specific activities the scout can not participate in.

The Scout and Parent signatures are required.

Complete this section for youth participants only:

Adults Authorized to Take Youth to and From Events:

You must designate at least one adult. Please include a phone number.
 Name: _____ Phone: _____
 Name: _____ Phone: _____

Adults NOT Authorized to Take Youth to and From Events:

Name: _____ Phone: _____
 Name: _____ Phone: _____

This section is optional, unless the scout will be picked up mid-week by someone other than a parent



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Fill this section out if there is someone that is not authorized to pick the scout up either mid-week or at the close of camp

**This section is to be completed by the parent,
NOT the doctor.**

Ignore this box on all pages, summer camp is not considered "High Adventure"

The council name is Connecticut Rivers

If no health insurance, write "None", do not leave blank.

This section is to be completed by the parent, NOT the doctor.

B1

Part B1: General Information/Health History

Full name: _____

Date of birth: _____

High-adventure base participants:
 Expedition/crew No.: _____
 or staff position: _____

Age: _____ Gender: _____ Height (inches): _____ Weight (lbs.): _____

Address: _____

City: _____ State: _____ ZIP code: _____ Phone: _____

Unit leader: _____ Unit leader's mobile #: _____

Council Name/No.: _____ Unit No.: _____

Health/Accident Insurance Company: _____ Policy No.: _____

Please attach a photocopy of both sides of the insurance card. If you do not have medical insurance, write "None".

In case of emergency, notify the person below:

Name: _____ Relationship: _____

Address: _____ Home phone: _____ Other phone: _____

Alternate contact name: _____ Alternate's phone: _____

Health History

Do you currently have or have you ever been treated for any of the following?

Yes	No	Condition	Diagnose
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	Last HbA1c percentage and date: _____ Insulin pump: Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Hypertension (high blood pressure)	
<input type="checkbox"/>	<input type="checkbox"/>	Adult or congenital heart disease/heart attack/chest pain (angina)/heart murmur/coronary artery disease. Any heart surgery or procedures. Explain at "yes" answers.	
<input type="checkbox"/>	<input type="checkbox"/>	Family history of heart disease or any sudden heart-related death of a family member before age 50.	
<input type="checkbox"/>	<input type="checkbox"/>	Stroke/TIA	
<input type="checkbox"/>	<input type="checkbox"/>	Adrenal/renal/urinary disease	Last attack date: _____
<input type="checkbox"/>	<input type="checkbox"/>	Lung/respiratory disease	
<input type="checkbox"/>	<input type="checkbox"/>	COPD	
<input type="checkbox"/>	<input type="checkbox"/>	Sarcoma/osteitis problems	
<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal conditions/injuries or bone issues	
<input type="checkbox"/>	<input type="checkbox"/>	Head injury/concussion/TBI	
<input type="checkbox"/>	<input type="checkbox"/>	Allergic reactions	
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric/psychological or emotional difficulties	
<input type="checkbox"/>	<input type="checkbox"/>	Neurological/neurological disorders	
<input type="checkbox"/>	<input type="checkbox"/>	Blood disorders/bleeding cell diseases	
<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells and dizziness	
<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	
<input type="checkbox"/>	<input type="checkbox"/>	Seizures or epilepsy	Last seizure date: _____
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal/gastrointestinal problems	
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	
<input type="checkbox"/>	<input type="checkbox"/>	Skin issues	
<input type="checkbox"/>	<input type="checkbox"/>	Obstructive sleep apnea/sleep disorders	CWAP: Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	List all surgeries and hospitalizations	Last surgery date: _____
<input type="checkbox"/>	<input type="checkbox"/>	List any other medical conditions not covered above	

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**This section is to be completed by the parent,
NOT the doctor.**

B2

Part B2: General Information/Health History

Full name: High-adventure base participants:
 Expedition/cove No.
 or staff position:

Date of birth:

Allergies/Medications

DO YOU USE AN EPINEPHRINE AUTOINJECTOR? Exp. date (if yes) YES NO

DO YOU USE AN ASTHMA RESCUE INHALER? Exp. date (if yes) YES NO

Are you allergic to or do you have any adverse reaction to any of the following?

Yes	No	Allergies or Reactions	Explain	Yes	No	Allergies or Reactions	Explain
<input type="checkbox"/>	<input type="checkbox"/>	Medication		<input type="checkbox"/>	<input type="checkbox"/>	Plants	
<input type="checkbox"/>	<input type="checkbox"/>	Food		<input type="checkbox"/>	<input type="checkbox"/>	Insect bite/stings	

List all medications currently used, including any over-the-counter medications.

YES, I take my medications as routinely taken. If additional space is needed, please list on a separate sheet and attach.

Medication	Dose	Frequency	Reason

YES, I take my prescription medication as prescribed or authorized with these exceptions:

Authorization of the above medications is approved for youth by:

(Parent/guardian signature) (M.D./D.O. or N.P. or Physician (if your state requires signature))

Immunization

The following immunizations are recommended. Tuberculin immunization is required and must have been received within the last 10 years. If you had the test, check the disease column and list the date. If immunized, check yes and provide the year received.

Yes	No	Disease	Date(s)
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculin	
<input type="checkbox"/>	<input type="checkbox"/>	Polio	
<input type="checkbox"/>	<input type="checkbox"/>	Diphtheria	
<input type="checkbox"/>	<input type="checkbox"/>	Mumps/measles/rubella	
<input type="checkbox"/>	<input type="checkbox"/>	Phos	
<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox	
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	
<input type="checkbox"/>	<input type="checkbox"/>	Meningitis	
<input type="checkbox"/>	<input type="checkbox"/>	Influenza	
<input type="checkbox"/>	<input type="checkbox"/>	Other (i.e., TB)	
<input type="checkbox"/>	<input type="checkbox"/>	Completion to immunizations (form required)	

Parent Signature

Doctor Signature

DO NOT WRITE IN THIS BOX.
 Review for camp or special activity.
 Reviewed by:
 Date:
 Further approval required: YES NO
 Reason:
 Approved by:
 Date:

Ignore this box on all pages, summer camp is not considered "High Adventure"

If there are **NO** medications taken regularly, check this box. Otherwise, list **ALL** regularly taken med's here.

Check Yes here to authorize **NON- Prescription** medication such as Advil, Tylenol, etc.

Parent Signature **REQUIRED** here, the **Doctor signature only required** if the Scout is on regular Prescription medication.

This section is to be completed by the parent, **optionally** you may attach a printout from the Doctors office of Immunizations.

Form "D"

Campsite: Arrow North
Troop: 102
Dates: 8/2/2020 – 8/8/2020

CONNECTICUT RIVERS COUNCIL BOY SCOUTS OF AMERICA

Last Name: _____ First Name: _____ Staff Leader Camper

Campsite: _____ Pack Troop Crew # _____ Dates Attending: _____

Part D
Connecticut Rivers Council Addendum to Annual BSA Health and Medical Records

This addendum to the Annual BSA Health and Medical Records is for youths and adults who are participating in a CRC camp program. This is required to meet Connecticut Department of Public Health requirements. Please read and sign the form at the bottom of the page.

If you disagree with any statements here, please cross out that section and initial it. Explain your wishes in the comment section, attaching an additional sheet if necessary.

- This medical form is correct so far as I know, and the person named in Part A has permission to participate in all camp activities except as noted on the form by me or by the doctor in Part B.
- In case of accident, injury or illness while at camp, I hereby give my permission to the doctor selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery or injections of medication.
- I hereby request that the camp's Health Officer administer the prescription and/or over-the-counter medication(s) ordered by my child's doctor/dentist. I understand that I must supply the camp with the prescribed medication in the original container as dispensed and properly labeled by a doctor or a pharmacist and will provide no more than is appropriate for my child's camp stay. I understand that this medication will be destroyed if not picked up within one week after my child leaves camp.
- I also give permission for my child to participate in trips sponsored by the camp and approved by the adult/unit leader in charge. Examples of these trips are whitewater merit badge, orienteering merit badges or trips for rock climbing or mountain biking.
- I give my permission for the Camp Health Officer to administer over-the-counter medications as directed for conditions as directed by the Camp Physician. Over-the-counter medications may include **WOUNDS:** Betadine, Hydrogen Peroxide, Bacitracin, Antibiotic ointment **POISON IVY:** Teconu, Benadryl cream **CANKER SORES:** Benzocaine cream **PAIN:** Tylenol, Ibuprofen **DYSMENORRHEA:** Ibuprofen **ABDOMINAL DISCOMFORT:** Tums, Meclox **HEADACHE:** Tylenol, Ibuprofen **HYPOLYCEMIA:** Glucose Gel, Glucagon **ALLERGIC REACTION:** Benadryl or generic, Epipen **ATHLETE'S FOOT:** Tinactin **INSECT STING/BITE:** Benadryl Cream, Hydrocortisone cream, Caladryl or Calagel, Epipen **TICK BITES:** Alcohol or Hydrogen Peroxide **1st DEGREE BURNS:** Burn Jell, Aloe Spray **EMERGENCIES:** Oxygen. Generics may be substituted.

This section must be signed to indicate acceptance of conditions above.

Signature: _____ Date Signed: ___/___/___
 (Adults over 18 sign here. Parent/Guardian signs for camper.)

Name (print): _____

Relationship: _____

Comments:

**Parent must sign,
 date, and print
 THEIR name, and
 indicate
 relationship to
 scout, mother,
 father, etc.**

This form is only required for Scouts with a disability or Special/serious Health Care Requirement .

Sample Form

Individual Plan of Care for a Child
With Special Health Care Needs or Disabilities

Child's Name: _____ Date of Birth ____/____/____

Special health care need or disability:

Plan for appropriate care of the child in a medical emergency. An individual Plan of Care is necessary when a child has a special health care need or disability and it is necessary that special care be taken or provided while the child is at the youth camp.

Other relevant information: (e.g. precautions to be taken to prevent a medical or other emergency)

Signature(s) of the Parent(s):

Date Signed:

____/____/____

____/____/____

NOTE: Section 428-3(a) requires a child's health record to include information regarding disabilities or special health care needs such as allergies, special dietary needs, dental problems, hearing or visual impairments, chronic illness, developmental variations or history of contagious disease, and an individual plan of care for the child with special health care needs or disabilities. The plan shall be developed with the child's parent(s) and health care provider and updated as necessary. Such plan of care shall include appropriate care of the camper in the event of a medical or other emergency and shall be signed by the parent(s) and staff responsible for the care of the camper.

Please use the reverse side of this form for signature(s) of all staff responsible for the care of this child.

One copy of this sheet must be completed for **each and every** medication the scout will be taking while at camp. If there are 3 medications listed on page B2, you need 3 copies of this sheet.

Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel

In Connecticut schools, licensed Child Day Care Centers and Group Day Care Homes, licensed Family Day Care Homes, and licensed Youth Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child 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's Order (Physician, Dentist, Optometrist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist):

Name of Child/Student _____ Date of Birth ____/____/____ Today's Date ____/____/____
 Address of Child/Student _____ Town _____
 Medication Name/Generic Name of Drug _____ Controlled Drug? YES NO
 Condition for which drug is being administered: _____
 Dosage _____ Method/Route _____ Time of Administration _____ Start Date ____/____/____ End Date ____/____/____
 Specific Instructions for Medication Administration _____
 Dosage _____ Method/Route _____
 Time of Administration _____ If PRN, frequency _____
 Medication shall be administered: Start Date: ____/____/____ End Date: ____/____/____
 Relevant Side Effects of Medication _____ None Expected
 Explain any allergies, reaction to/negative interaction with food or drugs _____
 Plan of Management for Side Effects _____
 Prescriber's Name/Title _____ Phone Number (____) _____
 Prescriber's Address _____ Town _____
 Prescriber's Signature _____ Date ____/____/____
 School Nurse Signature (if applicable) _____

Parent/Guardian Authorization:

I request that medication be administered to my child/student as described and directed above.
 I hereby request that the above ordered medication be administered by school, child care and youth camp personnel and I give permission for the exchange of information between the prescriber and the school nurse, child care nurse or camp nurse necessary to ensure the safe administration of this medication. I understand that I must supply the school with no more than a three (3) month supply of medication (except Epi-Pen).
 I have administered at least one dose of this medication to my child/student without adverse effects. (For child care only)

Parent/Guardian Signature _____ Relationship _____ Date ____/____/____
 Parent/Guardian's Address _____ Town _____ State _____
 Home Phone # (____) _____ Work Phone # (____) _____ Cell Phone # (____) _____

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse (if applicable) in accordance with board policy. In a school, inhalers for asthma and cartridge injectors for medically-diagnosed allergies, students may self-administer medication with only the written authorization of an authorized prescriber and written authorization from a student's parent or guardian or eligible student.

Prescriber's authorization for self-administration: YES NO _____ Signature _____ Date _____
 Parent/Guardian authorization for self-administration: YES NO _____ Signature _____ Date _____
 School nurse, if applicable, approval for self-administration: YES NO _____ Signature _____ Date _____

Today's Date _____ Printed Name of Individual Receiving Written Authorization and Medication _____
 Title/Position _____ Signature (in ink) _____

Note: This form is a sample form in compliance with Section 10-212a, Section 19a-79-8a, 19a-87b-17 and 19-11-B37a(v.)

The Doctor must sign each and every medication sheet

The parent must sign each and every medication sheet

This section is to be completed and signed if the scout uses an inhaler or Epi-Pen and it is to be Self Administered. A Doctor's signature is required for self-administered medication

All medication will be administered by the camp nurse, with the exception of doctor approved Epi-Pen or Inhalers
 (See next Page)

This form pertains specifically to treatment of allergies
It is a little redundant but must be completed.

**EMERGENCY TREATMENT PLAN FOR ALLERGIC REACTIONS AND ACUTE
RESPIRATORY DISTRESS AND THE PERMISSION TO ADMINISTER
MEDICATIONS BY CAMP PERSONNEL**

Food Allergy Asthma Bee/Wasp Stings Other

Patient's Name: _____ DOB: _____

Physician's Name: _____ Phone Number: _____

Specific Allergy: _____

If the patient thinks he/she has been exposed to the above named allergen:

- Observe patient for symptoms of anaphylaxis X 2 hours
- Administer Epinephrine before symptoms occur, IM: EPIPEN Adult EPIPEN JR
- Administer Epinephrine if symptoms occur, IM: EPIPEN Adult EPIPEN JR
- Administer Benadryl per appropriate age/weight dose
- Call 911, transport to ER

If the patient is experiencing respiratory distress (shortness of breath, wheezing, coughing):

- Administer PUFFS of _____ INHALER, REPEAT _____
- Call 911, transport to ER

Side effects, if any, to be observed: _____

CAMPER IS TO CARRY & MAY SELF-ADMINISTER EPIPEN / INHALER WHILE AT CAMP:

Yes No

Physician's Stamp: _____

Physician's Signature: _____ Date: _____

- I REQUEST THAT MEDICATION BE ADMINISTERED TO MY CHILD AS DIRECTED AND DESCRIBED ABOVE BY CAMP PERSONNEL AND GIVE PERMISSION FOR THE EXCHANGE OF INFORMATION BETWEEN THE PRESCRIBER AND CAMP NURSE AS NECESSARY TO ENSURE THE SAFE ADMINISTRATION OF THIS MEDICATION. I UNDERSTAND I MUST SUPPLY THE CAMP WITH THE NECESSARY MEDICATION.
- IF APPROVED BY THE PHYSICIAN ABOVE, I REQUEST AND GIVE MY PERMISSION FOR MY CHILD TO CARRY AND SELF ADMINISTER THE MEDICATION.

Parent/Guardian Signature: _____ Relationship: _____ Date: _____

Parent/Guardian's Address: _____ Town/State: _____

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

Rev. December 2010

This section is to be completed and signed if the scout will carry an inhaler or Epi-Pen. A Doctor's signature is required for self-administered medication

Parent must sign, date, and print THEIR name, and indicate relationship to scout, mother, father, etc.

Provide a copy of the FRONT and BACK of the health insurance card for the scout



[Redacted]

Identification Number

[Redacted]

Group No. [Redacted] MEDICAL COPAYMENT: \$0
BIN [Redacted] HSA PLAN
PCN [Redacted] A4
Rx Group WL7A
Plan Code 060



Members: If provider does not submit claims on your behalf, file medical claim: POB 533, North Haven, CT 06473-0533

anthem.com

Member Services: 1-888-224-4896
24/7 Nurseline: 1-866-800-8780
While Traveling: 1-800-810-2583
Provider Services: 1-800-922-3242
PreCertification: 1-800-238-2227
Pharmacist Svcs: 1-800-824-0898

Providers: file claims with your local BlueCross and/or BlueShield Plan; or when Medicare is primary, file claims directly with Medicare.

In Connecticut, Anthem Blue Cross and Blue Shield is the trade name for Anthem Health Plans, Inc. Independent licensee of the Blue Cross and Blue Shield Association. Anthem Blue Cross and Blue Shield provides administrative claims payment services only and, except for any stop-loss coverage that may be in effect, does not assume any financial risk or obligation with respect to claims.

Please include Member Name and Identification Number on all inquiries.
Possession of this card does not guarantee eligibility for benefits.

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