The Gunnery

Crew Camper Participant Information:

Participant Name:_____ DOB ____/____/_____
Last First MI

Health Insurance: YES ☐ NO ☐ Insurance Co._____ (Must include copy of Ins. card)

Allergies: YES ☐ NO ☐ _____

_____

If yes, please explain and list any medication your child/the participant will be carrying

Does your child/the participant take any medication YES ☐ NO ☐

_____

If yes, please list the medication. If they will be bringing it with them to Camp, please fill out the appropriate medical form.

Waiver and Release of Liability

The named participant or my child is in good health and I am unaware of any ailment, restriction or condition that would otherwise hinder or prevent him/her from participating in The Gunnery Camp. I therefore give my permission for my child/the participant to participate in a rowing clinic which will require physical exertion and operations on water. I understand there are potential risks associated with rowing, and waive, release and forever discharge The Gunnery and all Gunnery Camp directors, employees, staff, coaches and volunteers from any and all claims or liabilities for injury or loss of any kind which could arise out of participation in The Gunnery Camp. In the event that I cannot be reached, I give permission to The Gunnery Camp director, staff and coaches to act for me in their best judgment regarding any procedures or treatment in any emergency medical situation.

I understand that my child/the participant is subject to both the rules and regulations of the Camp and any company or organization that may be involved regarding conduct during participation in the Camp and that the Camp Director may terminate my child's/the participant's involvement with the Camp at any time for inappropriate conduct or other behavior deemed detrimental to the best interest of the Camp program, emergencies, or health or safety conditions or considerations.

I understand that an effort will be made to provide a lunch option that is mindful of any disclosed allergies my child/the participant may have, but in the event that that is not possible I agree to be responsible for providing lunch for my child/the participant.

I give the Camp permission to use, at their discretion, any Camp photos or videos of my child/the participant.

I, the undersigned, have read this consent and release and understand all its terms, and execute it voluntarily and with full knowledge of its significance. I also represent that I have legal capacity and authority to act for and on behalf of the child/participant named herein.

_____

Parent's/Guardian's name (please print)

_____ _____

Parent's/Guardian's signature Date

YOUTH CAMP HEALTH EXAM/RECORD
FOR CAMPERS AND STAFF

Physical Exams Are Valid For 3 Years
From Date of Last Examination

☐ Camper
☐ Staff

Please Return Completed Form to the Camp

Name_____ Date of Birth_____ Phone_____

Guardian_____ Address_____

Emergency Contact_____ Telephone_____

Date of Arrival at Camp: _____ Departure Date: _____

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/staff 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			Hepatitis B		
Mumps			Diphtheria		
Rubella			Pertussis		
Chickenpox			Pneumococcal conjugate		
Tetanus			Polio		

Comments: _____

_____

_____

Print name of medical care provider: _____

Medical care provider's address: _____

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

_____
Signature of Physician, PA, APRN or RN

_____
Date Form Signed

_____
Telephone Number

Allergy Action Plan

Name: _____ D.O.B.: ___/___/___

Allergy to: _____

Weight: _____ lbs. Asthma: ☐ Yes (higher risk for a severe reaction) ☐ No

Place Student's Picture Here

Extremely reactive to the following foods: _____

THEREFORE:

☐ If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten.

☐ If checked, give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted.

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

LUNG:	Short of breath, wheeze, repetitive cough
HEART:	Pale, blue, faint, weak pulse, dizzy, confused
THROAT:	Tight, hoarse, trouble breathing/swallowing
MOUTH:	Obstructive swelling (tongue and/or lips)
SKIN:	Many hives over body

Or combination of symptoms from different body areas:

SKIN:	Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT:	Vomiting, crampy pain

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
   -Antihistamine
   -Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTOMS ONLY:

MOUTH:	Itchy mouth
SKIN:	A few hives around mouth/face, mild itch
GUT:	Mild nausea/discomfort

1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring (see box below)

Medications/Doses

Epinephrine (brand and dose): _____

Antihistamine (brand and dose): _____

Other (e.g., inhaler-bronchodilator if asthmatic): _____

Monitoring

Stay with student; alert healthcare professionals and parent. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See back/attached for auto-injection technique.

Parent/Guardian Signature _____ Date _____ Physician/Healthcare Provider Signature _____ Date _____

TURN FORM OVER

Form provided courtesy of FAAN (www.foodallergy.org) 7/2010

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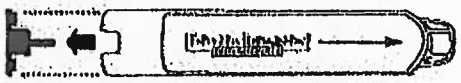
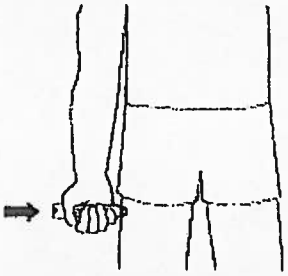
EPIPEN Auto-Injector and EPIPEN Jr Auto-Injector Directions

- First, remove the EPIPEN Auto-Injector from the plastic carrying case
- Pull off the blue safety release cap



- Hold orange tip near outer thigh (always apply to thigh)



- Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds. Remove the EPIPEN Auto-Injector and massage the area for 10 more seconds

EPIPEN 2-PAK® | EPIPEN Jr 2-PAK®

DEY® and the Dey logo, EpiPen®, EpiPen 2-Pak®, and EpiPen Jr 2-Pak® are registered trademarks of Dey Pharma, L.P.

Twinject® 0.3 mg and Twinject® 0.15 mg Directions

Remove caps labeled "1" and "2."

Place rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

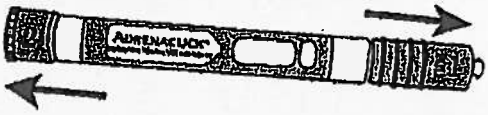
SECOND DOSE ADMINISTRATION:
If symptoms don't improve after 10 minutes, administer second dose:

Unscrew rounded tip. Pull syringe from barrel by holding blue collar at needle base.

Slide yellow collar off plunger.

Put needle into thigh through skin, push plunger down all the way, and remove.

Adrenaclick™ 0.3 mg and Adrenaclick™ 0.15 mg Directions



Remove GREY caps labeled "1" and "2."

Place RED rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

A food allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician, and a copy of this Food Allergy Action Plan.

A kit must accompany the student if he/she is off school grounds (i.e., field trip).

Contacts

Call 911 (Rescue squad: (___)____-_____) Doctor:_____ Phone: (___)____-_____

Parent/Guardian:_____ Phone: (___)____-_____

Other Emergency Contacts

Name/Relationship: _____ Phone: (___)____-_____

Name/Relationship: _____ Phone: (___)____-_____

Form provided courtesy of FAAN (www.foodallergy.org) 7/2010

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: _____

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 (school only.)

☐ I have administered at least one dose of the medication with the exception of emergency medications 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 or electronic) _____

Note: This form is in compliance with Section 10-212a, Section 19a-79-9a, 19a-87b-17 and 19-13-B27a(v.)

THE GUNNERY
MR. GUNN'S SCHOOL ESTABLISHED 1850

Permission to Treat Form

A COPY OF THIS FORM IS CONSIDERED AS LEGAL AND BINDING AS THE ORIGINAL

Parent or guardian to complete

Parent or Guardian Name

Student Name Date of Birth

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

As the parent or legal guardian of the above named student at The Gunnery, I hereby consent to the immediate transfer of the above student to any licensed hospital in the event of a medical emergency. I further consent to the administration of any emergency medical treatment deemed necessary by a licensed physician. I understand that all reasonable attempts will be made to contact me in advance of any treatment if the circumstances permit. I authorize The Gunnery to release information to facilitate the medical or surgical care of my child, or as is necessary to complete a claim for health insurance.

CONSENT TO MEDICAL TREATMENT FOR STUDENT BY THE GUNNERY MEDICAL DEPT.

I hereby authorize the Health Center of The Gunnery to administer medical care and treatment to the above named student and hereby consent to any medical care and treatment, including but not limited to the administration of medication and immunizations and referrals for psychiatric counseling or other medical care, including hospital inpatient and outpatient care. I further authorize The Gunnery and any licensed physician retained by The Gunnery to release medical records and/or information pertaining to the diagnosis or treatment of the above-named student when such disclosure is necessary for purpose of evaluation, treatment and any other supportive service to be provided to the above-named student or is necessary to complete a claim for health insurance.

I hereby authorize Emergency Medical Treatment AND treatment by The Gunnery Health Center as described above:

Parent Signature Relationship Date

Student Signature Date

** IF he/she will be 18 years old by the month of June in the current academic year.

PATIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone _____

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication

- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office
- ☐ O.K. to fax to this number

☐ Work Telephone _____

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Other _____

Parent/Guardian Signature Print name Date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and request for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency

Record of Disclosures of Protected Health Information

Date	Disclosed To	(1)	Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type key: T = Treatment Records; P = Payment Information; O = Healthcare Operations
(3) Enter how disclosure was made: F = Fax; P = Phone; E = Email; O = Other

Please list below all the children's names that you are given approval to:

_____