Form "A"

THE RUNNING ACADEMY CAMP "PERMISSION FORM"

(This form needs to be returned by July 30th)

Reasonable precaution is exercised to see that The Running Academy is a safe place for your child. Even so, it is possible that illnesses and accidents requiring medical treatment may occur. In either instance, it is important for the Camp Nurse to have certain medical information. Please fill in ALL appropriate information on this form, read and sign below.

Important- This must be completed to be enrolled at camp

ASSUMPTION OF RISK, WAIVER OF LIABILITY, RELEASE & AGREEMENT NOT TO SUE: In consideration for permitting my child/ward to participate in the The Running Academy at Camp Wah Nee, I voluntarily agree, for myself, my heirs, executors, and administrators, to the following: TO ASSUME FULL RESPONSIBILITY FOR ANY RISKS OR LOSS, OR PERSONAL INJURY, INCLUDING DEATH that may be sustained by my child/ward, or any loss or damage to property owned by me/my child/ward, as a result of training for, participating in, or traveling to/ or from the Summer Camp.

TO RELEASE, WAIVE, HOLD HARMLESS, DISCHARGE, & AGREE NOT TO SUE the Running Academy LLc, Camp Wah Nee, it's employees and sponsors from any and all liability, claims, actions, demands, expenses, attorneys fees, breach of contract actions, breach of statutory duty, or and causes of action whatsoever, that I might now have or may acquire in the future, arising out of/ or related to any loss, damage, or injury, including death, that may be sustained, or to any property belonging to me, while training for, traveling to or from, or participating in The Running Academy at Camp Wah Nee.

I hereby give permission to the camp to provide routine health care, administer prescribed medication and seek emergency medical treatment including ordering X- Rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange any necessary transportation.

In the event I cannot be reached in an emergency I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photo copied for trips out of camp.

I give permission for photographs taken of my child/ward while participating in the Summer Camp to be used in marketing/public relations material in the promotion of Summer Camp.

X _____ _____ ____/_____,2018

Parent or Guardian Printed Name Parent or Guardian Signature Date

Camper Name _____Sex____ DOB ___/____/_____

Parent or Guardian _____

_____

Home Address City State Zip

(_____)____-_____ (_____) _____-_____ (_____)____-_____

Home Phone Cell Phone Business Phone

If parent or guardian is not available in emergency, please notify:

Name_____ Relationship _____

_____

Address City State Zip

(____)_____-_____ (____)_____-_____ (_____)____-_____

Home Phone Cell Phone Business Phone

PLEASE Print out and COMPLETE PARTS A, B & Medical Authorization Form (if applicable).

Form B

THE RUNNING ACADEMY CAMP "HEALTH HISTORY"

(This form should be returned by July 24th – Please contact if physical is later.)

A CURRENT PHYSICAL EXAMINATION AND PHYSICIAN'S AUTHORIZATION IS REQUIRED TO PARTICIPATE IN SUMMER CAMP. AN UPDATED HEALTH HISTORY IS REQUIRED ANNUALLY. **If your child has had a physical since AUGUST 19th 2016, and if a signed copy of this physical and release to participate in all summer camp activities is attached to this form, you do not need a physician to sign below.**

"I have examined this child, and I release him/her to participate in all summer camp activities except those noted in item #9 below.

MD's Name (Print)_____

MD's Signature _____ **Date** _____/_____/2018__

_____ Phone (___)_____- _____

Address City State Zip

Medical Information to be filled out by Parent or Guardian: _____***:***

[Camper Name]

1. Allergies to Food or Medication (List types, reactions, preferred treatment)

_____

2. Dietary Restrictions or Special Diet Requirements:

_____

3. Date last Tetanus Booster _____ **Are other immunizations current**? ___

4. Operations or Serious Illness (types/dates)_____

5. Chronic / Recurring Illness (i.e. eating disorders, ear/throat infections, asthma, headaches, diabetes, seizures)

_____

_____

6. Recent Illnesses (past 3 months) _____

7. **Share other medical or social information that could help the nurse**.

_____

_____

8. All Prescription and "Over the Counter" Medications must be accompanied by Authorization for the Administration of Medication Form.

Medications brought to camp must be labeled with campers name and directions in their

ORIGINAL CONTAINERS

9. Additional Comments, Recommendations and/or Restrictions, regarding your child's diet and/or physical activities (athletics, running, sleeping, swimming, etc.) **while at camp:**

_____

_____

_____

10. Name (s) and Phone #' (s) of primary and other physicians currently treating your child:

_____

_____

Please mail all forms to:

The Running Academy c/o Marty Ogden, 31 Dairy Farm Dr., Brookfield, CT 06804

PLEASE Print out and COMPLETE PARTS A, B & Medical Authorization Form (if applicable).

The Running Academy

MEDICATION ADMINISTRATION AUTHORIZATION
for Summer Camp Only

In Connecticut, licensed camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the CT State Statutes and Regulations. **Parents/ guardians requesting medication administration to their child from camp staff shall provide the program with appropriate written authorization(s) and the medication before any medications are dispensed. 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. All unused medication will be destroyed if not picked up within one week following the camper's departure from camp.**

Medication shall only be administered by the health supervisor* or by a licensed health care professional authorized to administer prescription medications. The health care consultant shall acknowledge in writing the list of medications administered at the camp. If the health supervisor is not a licensed health care professional authorized to administer prescription medications, the administration of medications shall be under the professional oversight of the health care consultant. Medication prescribed for campers brought from home shall only be administered if it is from the original container, and there is written permission from the parent/guardian.

When no longer needed, medications shall be returned to a parent or guardian whenever possible. If the medication cannot be returned, it shall be destroyed.

**Health Supervisor – A person who is at least 18 years of age, specially trained and certified in at least current American Red Cross First Aid (or its equivalent) and CPR, has been trained in the administration of medications and is under the professional oversight of a licensed health care professional authorized to administer prescription medications.*

Instructions to Parents/Guardians

Page 2 of this Medication Administration Authorization form must be completed and signed by both you and the authorized Prescriber (Physician, Dentist, Physician Assistant, Advanced Practice Registered Nurse) for EVERY medication – whether over-the-counter (e.g., Advil) or prescription (e.g., Albuterol) – and each medication must have its own form.

Self-Administration Authorization applies to asthma and Epi-Pen medication only.

(Scroll down if there will be any medication given at camp)

Call 203-313-4955 if you have any questions

PLEASE Print out and COMPLETE PARTS A, B & Medical Authorization Form (if applicable).

This form needs to be mailed to 31 Dairy Farm Drive, Brookfield, CT 06804 ONLY if medication will be administered at camp.

MEDICATION ADMINISTRATION AUTHORIZATION CAMP

Authorized Prescriber's Order (Physician, Dentist, Physician Assistant, Advanced Practice Registered Nurse)

Only one medication per form, please.
Name of Camper _____ Date of Birth ___/___/___ Age ___ Today's Date ___/___/___

Medication Name _____ Controlled Drug? · YES · NO

Dosage _____ Method _____ Time of Administration/Frequency_____

Specific Instructions for Medication Administration (e.g., on empty stomach, with milk, etc.) _____

_____ Specify Precautions _____

Medication Administration: Start Date ___/___/___ Stop Date ___/___/___ Quantity Received _____

Expiration Date of Medications Received ___/___/___ Special Storage Requirements _____

Relevant Side Effects/Adverse Reactions _____

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 _____

Diagnosis (at parents discretion) _____

Camper may self- administer this medication · YES · NO Prescriber's Initials _____

Prescriber's Name_____ Business Telephone (____) _____

Prescriber's Signature _____ Prescriber's Emergency Telephone (____) _____

Prescriber's Address _____ Town/State/Zip _____

Parent/Guardian Authorization

I hereby authorize that medication be administered to my child as described and directed above and in accordance with CT State Statutes and Regulations and MA 105 CMR 430.160.

Name of Camp where medication administration will occur ___The Running Academy_____

Name of Parent/Guardian Authorizing Administration of Medication _____

Relationship to Child: · Mother · Father · Guardian/Other (explain): _____

Home Telephone (___) _____ Emergency Telephone (____) _____

Signature of Parent/Guardian _____ Today's Date ___/___/___

PLEASE Print out and COMPLETE PARTS A, B & Medical Authorization Form (if applicable).