



WESTERN CONNECTICUT STATE UNIVERSITY

Summer Music Participant Health Information

This form must be completed and signed by the participant's legal guardian for all participants who are under 18 or haven't completed high school in order to attend. The information we ask you to provide is necessary in the event your child needs medical treatment while the programs are in session. This form is due by JUNE 15th, 2009.

Participant Information

Camper Name _____ Date of Birth ____ / ____ / ____ Gender _____
Home Address _____
Street City State Zip
Home Phone (____) ____ - ____ 2009 Grade Completed: _____

Parent / Guardian Emergency Contact Information

Parent / Guardian _____ Relationship to Camper _____
Home Address _____
Street City State Zip
Home Phone (____) ____ - ____ Work Phone (____) ____ - ____
Cell Phone (____) ____ - ____ Usual Work Hours: _____

Parent / Guardian _____ Relationship to Camper _____
Home Address _____
Street City State Zip
Home Phone (____) ____ - ____ Work Phone (____) ____ - ____
Cell Phone (____) ____ - ____ Usual Work Hours: _____

Alternate Emergency Contact (non parent/guardian)

Name _____ Relationship to Camper _____
Home Address _____
Street City State Zip
Home Phone (____) ____ - ____ Work Phone (____) ____ - ____
Cell Phone (____) ____ - ____ Usual Work Hours: _____

Name _____ Relationship to Camper _____
Home Address _____
Street City State Zip
Home Phone (____) ____ - ____ Work Phone (____) ____ - ____
Cell Phone (____) ____ - ____ Usual Work Hours: _____

Allergies

Known Allergies to medications _____
Other known allergies (food / environmental) _____

Activity Restrictions

_____ My child has certain activity restrictions. Explain: _____

Prescription Medication

_____ My child will **not** take medication.

_____ My child will take medication. Please return one completed and signed Medication Authorization form for **each** prescription that your child will take. We are not able to administer medication without the completed authorization.

Over-the Counter Medication

Listed below are some of the over-the-counter medications approved by our camp physician for use by our camp health staff, in accordance with our treatment procedures. **You do not send these to camp.** Please indicate if your child may/may not be given these medications. (Please circle "yes" or "no" for each).

Ibuprofen (Advil)	Yes	No	Tums	Yes	No
Acetaminophen	Yes	No	Kaopectate	Yes	No
Benadryl	Yes	No	Pepto-Bismol	Yes	No
Sudafed	Yes	No	Mylanta	Yes	No
Robitussin Expectorant	Yes	No	Throat Lozenges	Yes	No

Insurance Information

Name of Insurer _____ Policy Number _____

PLEASE INCLUDE A COPY OF BOTH SIDES OF YOUR INSURANCE CARD.

Additional Information

Please use this space to provide us with any additional relevant information:

Medical Treatment Consent

I, the legal guardian of the above-named camper, give permission to WCSU Summer Music Camp Health Supervisor to provide routine health care, administer prescribed medications and seek emergency medical treatment as they see necessary at Danbury Hospital or another nearby facility. I consent to any x-ray, anesthetic, medical or surgical diagnosis or treatment and hospital care subsequently deemed necessary by a licensed health care provider during the participant's session. I understand that this authorization is given in advance of any specific diagnosis, treatment or hospital care, and that it is given to provide the Camp Director authority to seek medical treatment, and to provide a licensed health care provider the authority to administer this treatment as he/she judges necessary to the above-named child. I authorize any medical facility which renders services to release medical information necessary for the processing of insurance claims. I understand that whenever possible, the Camp Director will make a good faith effort to contact me or the above-named person(s) before seeking treatment. If this is not possible, I understand that the Camp Director will notify me or my designee as soon as possible of any and all diagnoses and treatments.

Signature of Parent / Guardian _____

Print Name: _____ Date: _____



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Summer Music Health Physical Exam Record

A physical examination is **required** within **3 years** of the final date that your child will attend the 2009 WCSU Summer Music programs. This form **must** be completed and signed by one of the specified medical practitioners listed in the signature section at the bottom of the form prior to participation in the summer music program. **Your child will not be permitted to participate in the program without a signed copy of this form on file.** This form is due by **JUNE 15th, 2009.**

Name _____ Date of Birth ____ / ____ / _____ Gender _____

TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER:

Date of Last Physical 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 participant is up-to-date on the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and National Advisory Committee on Immunization Practice:

	Date		Date
Measles		Hepatitis B	
Mumps		Diphtheria	
Rubella		Pertussis	
Chickenpox		Pneumococcal conjugate	
Tetanus		Polio	

Comments: _____

Print name of medical care provider: _____

Medical Care Provider's Address: _____

Street

City

State

Zip

Signature of Physician, PA, APRN or RN

Date Form Signed

Telephone Number