



**KUTSHER'S  
SPORTS  
ACADEMY**

**MEDICAL INFORMATION AND HEALTH HISTORY**

P O Box 252, Great Barrington MA 01230  
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Phone: 413-644-0077  
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The information on this form is part of the camper acceptance process, and is gathered to assist us in identifying appropriate care. This form must be completed and signed by parent/guardian AND physician.

Name \_\_\_\_\_

Birth date \_\_\_\_\_  Male  Female Age \_\_\_\_\_

Home Address \_\_\_\_\_

Street Address

City

State

Zip

Camper primarily lives with \_\_\_\_\_

Mother's Name \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Father's Name \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

If not available in an emergency, notify:

Name \_\_\_\_\_ Relationship to Camper \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Important – These boxes must be complete for attendance**

**Permission to Provide Necessary Treatment or Emergency Care:** I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for my child.

Signature of parent or guardian \_\_\_\_\_ Date \_\_\_\_\_

I also understand and agree to abide by the restrictions placed on my camp activities.

Signature of minor (camper) \_\_\_\_\_ Date \_\_\_\_\_





### MEDICAL INSURANCE INFORMATION

**This information will be given to health care providers – doctors, hospitals, pharmacies, etc. as required.**

Camper's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Family Name \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone(s) \_\_\_\_\_

Medication Allergies \_\_\_\_\_

Amount of Co-Pay (deductible) \_\_\_\_\_

Medical Insurance Carrier Name \_\_\_\_\_

Insurance Co Address \_\_\_\_\_

Insurance Co Phone Number \_\_\_\_\_

Insurance ID number \_\_\_\_\_

Certification Number \_\_\_\_\_

Group Number \_\_\_\_\_

Name of Insured \_\_\_\_\_

Relationship to Camper \_\_\_\_\_

**If we need to order prescription medications for your child, we will call to let you know. Please provide a credit card number we can use to charge such expenses to:**

Card # \_\_\_\_\_ Expiration \_\_\_\_\_

Security Code \_\_\_\_\_ Billing Zip Code \_\_\_\_\_

Cardholder Signature \_\_\_\_\_





**TO BE FILLED OUT BY PHYSICIAN - Doctor may use his/her own form**

Camper Name \_\_\_\_\_

I have examined the above camp participant. Date of last examination \_\_\_\_\_

BP \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

In my opinion, the above applicant:  is  is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions:

Current treatment at the time of this report includes:

Recommendations and Restrictions at Camp – Please indicate any of the following about which the camp should be aware.

- Treatment to be continued at camp
- Medications to be administered at camp (name, dosage, frequency)
- Any medically-prescribed meal plan or dietary restrictions
- Known allergies
- Description of any limitation or restriction on camp activities:
- Please provide any additional info about the camper's behavior and physical, emotional, or mental health

I have examined the patient herein described and have reviewed the health history. It is my opinion that this child is physically able to engage in the regular camp activities, except as noted. Please be aware that this constitutes a doctor's order. Children will not receive medication other than that which is listed above.

Physician's Signature \_\_\_\_\_

Physician's Name \_\_\_\_\_ Physician's Phone # \_\_\_\_\_



**TO BE FILLED OUT BY PHYSICIAN \* \* Doctor may use his/her form**

Camper Name \_\_\_\_\_

**Massachusetts State Law requires this section to be filled out by a physician in order for our nurses to dispense over-the-counter non-prescription medication to your child when needed.**

DRUGS	ROUTE	DOSAGE	SCHEDULE	PROVIDER ORDER	COMMENTS
Tylenol	PO (chewable tabs elixer or tabs)	Per label instructions by age/weight	Q 4 hr prn for pain or fever>	Yes / No	
Ibuprofen	PO (chewable tabs elixer or tabs)	Per label instructions by age/weight	Q 4 hr prn for pain or fever>	Yes / No	
Robitussin	PO (chewable tabs elixer or tabs)	Per label instructions by age/weight	Q 4 hr prn for cough	Yes / No	
Pepto-Bismol	PO (chewable tabs elixer or tabs)	Per label instructions by age/weight	Q 2-4 hr prn for diarrhea (no>8 doses/24 hr)	Yes / No	
Children's Mylanta	PO (chewable tabs elixer or tabs)	Per label instructions by age/weight	BID-TID for upset stomach	Yes / No	
Dramamine	PO (chewable tabs elixer or tabs)	Per label instructions by age/weight	Q 6-8 hrs for motion sickness	Yes / No	
Phenylephrine	PO (chewable tabs elixer or tabs)	Per label instructions by age/weight	Q 6-8 hrs prn for nasal congestion/drainage	Yes / No	
Benadryl	PO (chewable tabs elixer or tabs)	Per label instructions by age/weight	Q 6 hr prn for allergic reaction (hives, insect bites)	Yes / No	
Hydrocortisone	PO (cream)	Per label instructions by age/weight	Q prn for rash	Yes / No	
Triple Antibiotic	PO (ointment)	Per label instructions by age/weight	Q prn for minor bacterial infections	Yes / No	
Imodium	PO (chewable tabs elixer or tabs)	Per label instructions by age/weight	Q 2-4 hr prn for diarrhea (no> 8 doses/24 hr)	Yes / No	

**Immunization - Which of the following has the participant had: Please give all dates of immunization:**

<input type="checkbox"/> Measles	Vaccine – Dates	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
<input type="checkbox"/> Chicken Pox	DTP						
<input type="checkbox"/> German measles	TD (tetanus/diphtheria)						
<input type="checkbox"/> Mumps	Tetanus						
<input type="checkbox"/> Hepatitis	Polio						
	MMR						
	Or measles						
	Or Mumps						
	Or Rubella						
	Haemophilus influenza B						
	Hepatitis B						
	Varicella (chicken pox)						
	BCG						

TB Mantoux Test:  
Date of last test \_\_\_\_\_  
Result:  
 Negative  
 Positive



Dear Parent:

Kutsher's Sports Academy is required to maintain a record of the following for each camper:

- A record of meningococcal meningitis immunization within the past 10 years; OR
- An acknowledgement of meningococcal meningitis disease risks and refusal of meningococcal meningitis immunization signed by the camper's parent or guardian.

Meningitis is rare. However, when it strikes, its flu-like symptoms make diagnosis difficult. If not treated early, meningitis can lead to swelling of the fluid surrounding the brain and spinal column as well as severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation and even death.

Cases of meningitis among teens and young adults 15 to 24 years of age have more than doubled since 1991. The disease strikes about 3,000 Americans each year and claims about 300 lives. A vaccine is available that protects against four types of the bacteria that cause meningitis in the United States - types A, C, Y and W-135. These types account for nearly two-thirds of meningitis cases among teens and young adults.

Information about the availability and cost of the vaccine can be obtained from your health care provider and by visiting the manufacturer's website at [www.meningitisvaccine.com](http://www.meningitisvaccine.com).

To learn more about meningitis and the vaccine, please feel free to contact the Kutsher's Sports Academy office (413-644-0077) and/or consult your child's physician.

You can also find information about the disease at the Massachusetts State Department of Health website at <http://www.mass.gov/dph/> and the website of the Center for Disease Control and Prevention at [www.cdc.gov/ncidod/dbmd/disease/info](http://www.cdc.gov/ncidod/dbmd/disease/info).

Sincerely,

Marc White

*Massachusetts State Public Health Law requires the operator of an overnight children's camp to maintain a completed response form for every camper who attends camp for seven (7) or more nights.*

**Check one box and Sign Below**

My child has had the meningococcal meningitis immunization (Menomune™) within the past ten years.

Date Received \_\_\_\_\_

I have read or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine and have decided that my child will **not** obtain immunization against this disease.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
(Parent or Guardian)

Camper's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_



**Health History for Camper Name \_\_\_\_\_**

The following information must be filled in by the parent/guardian.

Has your child had any of the following: (check all that apply)

- Recent injury or illness
- Chronic/reoccurring condition
- Ever had surgery
- Ever been hospitalized
- Frequent headaches
- Ever have a head injury
- Ever been knocked unconscious
- Glasses, contacts, eye wear

- Back problems
- Joint Problems
- Skin Problems
- Diabetes
- Asthma
- Recurring Diarrhea/ Constipation
- Sleep walking
- Bed wetting
- Eating disorders
- Mononucleosis in the past 12 months

During or after exercise, has your child ever:

- Passed out
- Been dizzy
- Had chest pain

Is your child allergic to:

- Penicillin
- Sulfa
- Aspirin
- Hay Fever
- Animal Dander
- Dairy
- Insect Stings
- Peanut / Nut
- Food

**Medications Being Taken**

Please list ALL medications (including over-the-counter or non-prescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

This person takes medications as follows:

Med # 1 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Med # 2 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Med # 3 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Attach additional pages for more medications.

Identify any medications taken during the school year that participant does/may not take during the summer.

**Dietary Restrictions:**

- Does not eat red meat
- Does not eat pork
- Does not eat eggs
- Does not eat poultry
- Does not eat seafood
- Does not eat dairy products

Other dietary restrictions:

Name of family physician \_\_\_\_\_ Phone \_\_\_\_\_

Name of family dentist \_\_\_\_\_ Phone \_\_\_\_\_

Name of family orthodontist \_\_\_\_\_ Phone \_\_\_\_\_

**Parent/Guardian Authorizations:** This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted.

Signed \_\_\_\_\_ Printed \_\_\_\_\_ Date \_\_\_\_\_