



New Canaan Nature Center

**Eco-Rangers  
2008**

**2008 Summer Eco-Rangers Program -- Camper Information Form**

**Camp Week (please check appropriate week(s):**

- Field Zoology
- Fly High
- Wildlife Cinema Adventure
- Crime Scene Camp
- Adventure Connecticut
- Roller Coasters, Rockets & Rails
- Aquatic Adventures
- State Park Explorers

**Camper information:**

Camper's Name: \_\_\_\_\_

DOB:    /    /    Grade Entering:    Sex: B    G

**Contact information:**

Home Telephone: \_\_\_\_\_

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

City/State/Zip: \_\_\_\_\_

e-mail address: \_\_\_\_\_

Parents'/Guardians' Names: \_\_\_\_\_

Daytime Phone (1): \_\_\_\_\_

Daytime Phone (2): \_\_\_\_\_

**Emergency information:**

Emergency contacts (authorized to remove child from premises):

1) Name: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_

2) Name: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_

Child's Doctor: \_\_\_\_\_

Office Phone: \_\_\_\_\_

Health Insurance Carrier: \_\_\_\_\_

Insured's name: \_\_\_\_\_

Policy or Group #: \_\_\_\_\_

**VERY IMPORTANT:** Please list any known allergies, medications, physical limitations, special needs, emergency medical information or anything else we should know about your child (including medications taken during the school year but not in the summer):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please sign releases & return this form to the New Canaan Nature Center by May 30, 2008!**

**CAR POOL PERMISSION:** Your child will only be allowed to leave camp with authorized above or on the list below. Any changes or additions must be given in writing to your child's teachers. Please list babysitters, car pool partners and any friends or relatives you anticipate may pick up your child. **Parents, guardians and emergency contacts already listed above DO NOT need to be listed again below.**

I hereby grant permission to the New Canaan Nature Center to release my child to the custody of the following:

Name	Phone
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**FIELD TRIP PERMISSION (Adventurers, Trackers And Eco-Rangers):** The majority of the Adventurers and Eco-Rangers camp programs and some Trackers programs and activities take place away from the Nature Center grounds. Parents are notified in advance, in writing, of the itinerary of all field trips and overnight excursions, including information on how the children will be transported. In order for your child to participate on these trips, you must sign below.

I grant permission for my child to leave the grounds of the New Canaan Nature Center in order to participate in the Adventurers, Eco-Rangers and Trackers camp programs.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**EMERGENCY RELEASE:** The health information provided on this and the medical/health history form is complete and correct so far as I know. The person described herein has my permission to engage in all camp activities except as noted by me or the examining physician.

In the event of an emergency, I hereby give permission for the staff of the NCNC to administer first aid and/or obtain emergency medical treatment for the child herein described. If my child has been prescribed medication to treat an allergic reaction (including but not limited to an Epi-Pen or inhaler) I hereby give permission for my child to self-administer said medication at NCNC. I understand that every effort will be made to contact me and/or emergency listings. If I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and/or order injection, anesthesia or surgery for the person named above. I understand that, if necessary, this child will be transported by New Canaan Ambulance Corps to Norwalk Hospital. In the case of campers who are away from NCNC grounds, I understand that, if necessary, this child will be transported to the nearest emergency facility. I agree that any cost incurred for transportation and/or treatment will be my responsibility.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**PHOTO RELEASE:** I hereby give permission for my child's photograph to be taken while participating in camp activities and to be used in New Canaan Nature Center publications, and for advertising and promotions for the New Canaan Nature Center.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**New Canaan Nature Center  
YOUTH CAMP HEALTH EXAM/RECORD  
FOR CAMPERS AND STAFF  
Physical Exams Are Valid For 3 Years  
From Date of Last Examination**

**Please Return Completed Form to Camp**

- Camper  
 Staff

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 medication?  YES  NO  
If yes, indicate prescription: \_\_\_\_\_

Does the individual have allergies?  YES  NO Explain: \_\_\_\_\_

Is the individual on a special diet?  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			Polio		
Tetanus					

Comments: \_\_\_\_\_

Print name of medical care provider: \_\_\_\_\_

Medical care provider's address: \_\_\_\_\_

Medical care provider's: City/Town \_\_\_\_\_ ST \_\_\_\_\_ Zip Code \_\_\_\_\_

\_\_\_\_\_  
Signature of Physician, APRN or PA

\_\_\_\_\_  
Date Form Signed

\_\_\_\_\_  
Telephone Number

**A Signed Form for Each  
Medication is Required  
by State Law**

**New Canaan Nature Center**

**AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATIONS  
(PERSCRIPTION) BY YOUTH CAMP PERSONNEL**

If a Youth Camp chooses to administer medications, the Connecticut State Law and Regulations require an authorized prescriber (M.D., P.A, APRN) or dentist's written order and parent or guardian's authorization for a nurse or camp personnel with current Medication Administration Training to administer medications. Medications must be in pharmacy prepared containers and labeled with the name of the child, name of the drug, strength, dosage, frequency, authorized prescriber or dentist's name and date of the original prescription. Over the counter medication must be in the original container and labeled with the child's name. **(This Section MUST be SIGNED by a Physician!)**

**AUTHORIZED PRESCRIBER: PHYSICIAN'S OR DENTIST'S ORDER: Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of Child \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Street Address \_\_\_\_\_ City/Town \_\_\_\_\_ State \_\_\_\_\_

Condition for which drug is being administered during camp hours \_\_\_\_\_

DRUG: Name of Drug, Dose and Method of Administration \_\_\_\_\_

Times of Administration: \_\_\_\_, \_\_\_\_, \_\_\_\_ Medication shall be administered from \_\_\_\_/\_\_\_\_/\_\_\_\_ - \_\_\_\_/\_\_\_\_/\_\_\_\_

Relevant side effects to be observed, if any \_\_\_\_\_

If there are side effects, plan for management \_\_\_\_\_

Is this a controlled drug? \_\_\_\_\_

Allergies, reaction to, or negative interaction with food or drugs? If YES, list \_\_\_\_\_

The authorized Physician's or Dentist's Name \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

**(Print Name Clearly)**

Street Address \_\_\_\_\_ City/Town \_\_\_\_\_ State \_\_\_\_\_

**Authorized Prescriber: Physician's or Dentist's Signature** \_\_\_\_\_

**Authorization by Parent/Guardian for the administration of the above medication: Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**(Parents Signature Required!)**

I hereby request that the above medication, ordered by the authorized prescriber: physician/dentist for my child \_\_\_\_\_, be administered by the nurse or by camp personnel with current Medication Administration Training.

I understand that I must supply the Youth Camp with the prescribed medication in the original container dispensed and properly labeled by an authorized prescriber, dentist or pharmacist. Over the counter medication shall be in the original container labeled by the parent with the child's name.

I understand that this medication will be destroyed if it is not picked up within one (1) week following termination of the order.

Name of Parent or Guardian \_\_\_\_\_ **Signature** \_\_\_\_\_

**(Print Name Clearly)**

Relationship to child \_\_\_\_\_ Street Address \_\_\_\_\_

City/Town \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

**Adventure Camp**

This form **Must** be signed  
by a Physician and Parent

**New Canaan Nature Center  
Nonprescription Medication Permission Form  
(Authorization to Administer/Dispense Nonprescription Medications)**

Connecticut State Law requires an authorized prescriber's (M.D., DDM, P.A., APRN) written order & parent/guardian's authorization for a nurse or youth camp personnel with current Medication Administration Training to dispense/administer medications. The New Canaan Nature Center can provide storage for nonprescription/ prescription drugs, including inhalers and epi-pens, and will provide appropriate supervision while your child takes the medication with your permission and as instructed by your physician.

**Please complete and sign this form and return it to the Nature Center by May 31 (or at least 2 weeks prior to start of the camp session.)**

I hereby grant permission for authorized staff of the New Canaan Nature Center to store, administer/ dispense and supervise the consumption of nonprescription medication, as instructed by me, and directed by our physician, for my child, \_\_\_\_\_ (name).

While attending \_\_\_\_\_ (program name(s))

On \_\_\_\_\_ (dates)

I understand that this medication will be destroyed if it is not picked up within one week after the end of this session.

**Please list on the back of this form all medications, the condition for which the drug is being administered, the correct dosage, a schedule of the times it is to be taken, and possible side effects. If there are side effects, please provide a plan for management of these effects.**

**Note:** All medications must be in **original** containers and clearly labeled with the following information:

- child's name
- name of drug
- strength
- dosage, frequency & method of administration
- physician's name & phone number

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent or Guardian's Signature)

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Physician's name: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Physician's Signature)

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

**See Reverse**

**Note: Connecticut State Law requires that this *Nonprescription Medication* form be filled out completely if your child is to receive ANY nonprescription medications. Be sure the form is signed by a physician & a parent or legal guardian.**

**CHILD'S NAME:**

<b>Medication</b>	<b>Dosage</b>	<b>Frequency</b>	<b>Condition</b>	<b>Side Effects</b>	<b>Plan for Management of Side Effects</b> (if you need more room, please use an additional sheet)

**See Reverse**