Summer Place Programs
University of Hartford
200 Bloomfield Avenue
West Hartford, CT 06117
Phone 860.768.4432
Fax 860.768.4233

2026 Summer Place Camper Medical Record

The State of Connecticut requires that all campers submit an up-to-date medical record. Failure to submit medical forms required by state law will result in automatic unenrollment from camp.

This page should be completed by parents/guardians of campers. The second page is to be completed and signed by your child's physician, and may be based on an exam conducted any time since **August 7, 2023.** School health forms with immunizations can be accepted in place of the second page of this form.

If medication needs to be administered while your child is at camp, including an EpiPen or inhaler, please complete and email an ***Authorization of Medication*** form and an ***Individual Care Plan*** form, listed under Medical Forms on our website. Medicines with specific instructions can be dispensed from the nurse's office.

Completed and signed medical forms MUST be returned to us by May 1, 2026.

Please print, fill out, scan, and email the forms to splace@hartford.edu.

Camper Name________________________________Sex____Gender____Birth Date_______Grade (Fall '26) _____

Camper's Current School _________________________________Location of School _______________________

Home Address____

Parent/Guardian Phone Numbers:

Name __________________________________Home_______________Cell______________Work__________

Name __________________________________Home_______________Cell______________Work__________

Indicate program/session(s) your child is enrolled in:

Summer Place Week 1 ❑ Week 2 ❑ Week 3 ❑ Week 4 ❑ Week 5 ❑ Week 6 ❑

Kinderplace/Li'l Place Week 1 ❑ Week 2 ❑ Week 3 ❑ Week 4 ❑ Week 5 ❑ Week 6 ❑

SP Leaders in Training (SPLIT) Weeks 1-2 ❑ Weeks 3-4 ❑ Weeks 5-6 ❑

Allergies: List all known ____

This camper has the following issues that may affect their camp experience:

☐ Vision ☐ Auditory ☐ Speech/Language ☐ Physical Dysfunction ☐ Emotional/Social ☐ Behavior

Disability or chronic or recurring illness ____

Is there any other health-related information that should be shared with appropriate staff members?

____

Please indicate which, if any, of the following your child may be given at camp as needed:

Acetaminophen ___ Ibuprofen ___ Benadryl ___ Calamine ___Antibiotic Ointment ___Insect Repellent ___Sunscreen___

PERMISSION TO PARTICIPATE AND AUTHORIZATION FOR EMERGENCY TREATMENT

To the best of my knowledge, this health history is correct. My child has my permission to participate in all camp activities, except as noted by me or the examining physician. Summer Place has made me aware of its policies regarding concussions. If I cannot be reached in an emergency, I authorize the Summer Place camp physician to hospitalize, secure proper treatment for, and order injections and/or anesthesia for surgery for my child, as deemed necessary.

Signature (Parent/Guardian)________________________________ Date ________________________

UNIVERSITY OF HARTFORD

Name of Camper________________________ **Date of Exam_____________________**

TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER:

This camper 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			Pneumococcal Conjugate Vaccine		
Hepatitis A			Menactra		

This camper has the following issues that may affect their camp experience:

□ Vision □ Auditory □ Speech/Language □ Physical Dysfunction □ Emotional/Social □ Behavior

□ The camper has a health condition that may require emergency action at camp; e.g., seizures, allergies, anaphylaxis.

Please specify if checked:____

Is this individual taking prescription medication? □ YES □ NO
If yes, indicate medication:____

Does the individual have allergies? □ YES □ NO
If yes, please explain:____

Is the individual on a special diet? □ YES □ NO
Explain:____

May participate in all camp activities: □ YES □ NO

May participate except for: ____

Medical information pertinent to routine care and emergencies: _______________________________

Print name of medical care provider: ____

Medical care provider's address: ____

City/Town ___________________________ State _________________________ Zip Code ___________________________

____
Signature of Physician, APRN or PA

____
Date Form Signed

____
Telephone Number