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

2025 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 8, 2022.** School health forms accepted.

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, 2025.

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

Camper Name_____Sex_____Birth Date_____Grade (Fall '24) _____

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 _____

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