Melwood Recreation Center
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www.melwoodrecreation.org

2019 MEDICAL & MEDICATION FORM

Must be submitted at least 4 weeks prior to attendance.

This form must be filled out ANNUALLY. This 4-page form requires a doctor's signature!

Name: **DOB:**

Health History *Please check and explain any past health issues*

- ☐ Heart defect/disease
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Ear Infections
- ☐ Asthma
- ☐ Mumps
- ☐ Chicken Pox
- ☐ Hay Fever
- ☐ Measles
- ☐ Swimmer's Ear
- ☐ Poison Ivy
- ☐ Mononucleosis
- ☐ Other: _____

Explain: _____

Does this person have an active seizure condition? ☐ Yes* ☐ No Type: _____

Frequency: _____ Length of seizure: _____ Triggers: _____

If yes, please attach a copy of the seizure plan

Does this person have any hearing issues? ☐ Yes ☐ No
If yes, describe: _____

Does this person have any vision issues? ☐ Yes ☐ No
If yes, describe: _____

Does this person have any allergies? ☐ Yes ☐ No
If yes, describe: _____

Should treatment for allergies be performed by a physician? ☐ Yes ☐ No
Can treatment for allergies be administered in absence of a physician? ☐ Yes ☐ No

Does this person have any dietary restrictions? ☐ Yes ☐ No if yes, describe: _____

Health Insurance: _____ Policy Number: _____

(Please attach a copy of the health insurance card, both back and front, and submit with your paperwork)

Is this person exempt from any immunization requirements? ☐ Yes ☐ No if yes, include documentation

Is this person enrolled in Maryland state schools? ☐ Yes ☐ No if no, please see below

PLEASE SUBMIT IMMUNIZATION RECORDS WITH THIS MEDICAL FORM. ANYONE NOT HAVING AN IMMUNIZATION RECORD THAT IS WITHIN ONE YEAR OF COMPLETION, MUST SUBMIT A NEW ONE.

Medical Release & Authorization *Must be signed by the legal guardian*

In case of emergency, I understand that every effort will be made to contact the legal guardian or the emergency contacts listed on the individual's registration form. In the event that legal guardian or emergency contact cannot be reached, permission is given to Melwood to secure proper treatment including hospitalization, necessary tests, surgery, anesthesia or injections of medication for me/the individual. Permission is given to transport the individual for medical assistance. It is understood that the individual or the legal guardian is responsible for payment of all medical treatment. Medical and Medication form may be photocopied for use. State regulations require permission to allow Melwood to administer medications to the individual while at camp or recreation program. It is required that the first dose of all medication be administered at home. Exceptions can be made at the discretion of Senior Management. I hereby give my permission for Certified Medication Administration staff to give medication to the individual while they are at camp.

Legal Guardian Name (Please Print): _____
Legal Guardian Signature: _____ Date: _____

Emergency Contact: _____Contact Number: _____

Medical Exam Information *To be completed by a health care provider and dated within 1 year of program. Completion of this form is **mandatory** regardless of submission of medical exam copies!*

Blood Pressure: _____ Weight: _____ Height: _____

Is this person able to participate in an active camp and/or recreation program? ☐ Yes ☐ No
For participants with Down syndrome; by initialing here, I certify that there is no presence of AAI and the individual is Able to participate in horseback riding: _____ (doctor's initial's required or attach a copy of AAI Release).

Any limitations or restrictions while at camp? ☐ Yes ☐ No

If yes, describe:

_____

Any medical concerns to be monitored at camp? ☐ Yes ☐ No
If yes, describe:

_____

Any meal plans or dietary restrictions to be monitored at camp? ☐ Yes ☐ No
If yes, describe:

_____

Date of Physical Exam: _____ ***MUST BE WITHIN ONE YEAR OF ATTENDANCE***

I certify that I have completed a physical examination of this person on the date listed above. This person is in satisfactory condition to participate in an active camping or recreation program. I am aware of all medications prescribed to this individual and see no contra-indications. This person can also receive as needed medications and treatments when deemed necessary by Melwood health staff and as outlined in the Melwood Recreation Center standing orders and the Medication form.

Physician's Name (Please Print): _____

Physician's Signature: _____ Date: _____

Address: _____

Phone Number: _____

Name: _____ DOB: _____
Legal Guardian: _____ Contact Number: _____
Emergency Contact: _____Contact Number: _____

Medication Administration Regulations: *Please read carefully!*

In order to participate in Recreation Center programs, this form **Must** be filled out accurately! If changes are made in the individual's medication administration once this form is completed, you are responsible for providing accurate updates or the individual may not be allowed to stay.

- This form must include all **medications and treatments** prescribed to this individual that includes lotions, inhalers, liquids, allergy medications, cold medications, temporarily prescribed medications. Sample medications **will not** be administered without the proper prescription label.
    - **Recreation Center staff CANNOT administer injectable medications.** Please contact the main office to discuss options if the participant takes an injectable medication.
- Each medication listed must include accurate dosages, times and instructions.
- Each medication order page must be signed by a physician. ***No exceptions will be made!***
- Any medication that has been added after this form is completed or if there are changes in dose, time or frequency of medication **must** be accompanied by a written physician's order or a new form.
- Any medication listed on this form that is not brought to the Recreation Center **Must** have an order to discontinue by physician.
- Labels on medication containers **Must** match this form.
- No foreign prescriptions without proper labeling.
- Medications must be kept in their original containers and have a current pharmacy label that matches the doctor's order.
- All medications will be returned to me or designee at the time of pick up. Any medications not retrieved within 7 days, will be properly disposed of.

It is the responsibility of the guardian or caretaker to ensure that there are no contra-indications or interactions of the medications listed on the Medication Form.

I have read the above regulations and by signing below I agree that the medications listed on this form are accurate. I am aware that on intake day, if the medications brought do not match the medications listed or any of the above terms are not met, the participant will be sent home and is not eligible for a refund.

By signing below, I authorize Recreation Center staff to administer medications as ordered and listed on this form. I understand the above guidelines and agree to follow them.

Legal Guardian Signature: _____ Date: _____

Legal Guardian Name (Please Print): _____ Date: _____

****THIS SECTION IS TO BE USED FOR CAMP ACCOMPLISH USE ONLY****

Over the Counter Medication – As Needed Authorization
Please check and sign medication that can be administered at camp under our standing orders by the camp physician. Please note you will not need to bring these medications to camp. Only medications typed on this form are approved.

☐ Acetaminophen	☐ Mylanta	☐ Triple Antibiotic Ointment
☐ Tinactin	☐ Tussin	☐ Iburofen
☐ Milk of Magnesia	☐ Medicated Throat Spray	☐ Hydrocortisone Cream
☐ Imodium	☐ Dimetapp	☐ Guaifenesin
☐ Sudafed	☐ Sunscreen	☐ Benadryl
☐ Bacitracin Ointment	☐ Calamine Lotion	☐ Medicated Throat Spray

Legal Guardian Name (Please Print): _____ Date: _____

Legal Guardian Signature: _____ Date: _____

Name: ______________________________________ DOB: ___________ Allergies: ____________

CAN THIS PARTICIPANT SELF-MEDICATE? Yes   No

Please complete this form thoroughly and accurately. A physician's signature is required below.
Please use an additional sheet if necessary.

MEDICATION ORDERS ARE VALID FOR ONE YEAR FROM DATE OF DOCTOR'S SIGNATURE

It MUST include all *prescription*, *routine over the counter* and as needed medications (not listed on the back of this page) to be given while on a recreation program. Medications will be dispensed at **B**-Breakfast (8:45am), **L**-Lunch (12:30pm), **D**-Dinner (6:00pm), **HS**-Hour of Sleep (8:15pm) unless otherwise specified.

We cannot accept PMOFs (Physician's Medication Order Forms)!

***Please include any other special equipment or treatments (i.e. C-PAP, glucose checks, and special diet)**

NAME OF MEDICATION STRENGTH OF EACH INDIVIDUAL MEDICATION & ROUTE	DOSAGE AT EACH TIME	TIMES USE B, L, D, HS IF POSSIBLE	PURPOSE OF MEDICATION SPECIFIC DIAGNOSIS

Please list any other medical concerns to be monitored while in the program: ______________________________

____

*I have reviewed the above medications and hereby authorize Recreation Center staff to administer as prescribed

Physicians Signature: _______________________________ **Date:** _____________________

Printed Name: _______________________________________ **Phone:** ____________________