Hello, Welcome to Celtics Camps!

Please read this document, as there have been changes to processing paperwork for camp.

* **IF REGISTERING BEFORE APRIL:** PAPERWORK IS DUE BY MAY 9th
* **IF REGISTERING AFTER MAY 1:** PAPERWORK IS DUE WITHIN TWO WEEKS OF ONLINE REGISTRATION
* **IF REGISTERING AFTER JUNE 1:** PAPERWORK IS DUE UPON ONLINE REGISTRATION

**REGISTRATION IS INCOMPLETE UNTIL MEDICAL PAPERWORK IS SENT TO THE CAMP DOC SECURED WEBSITE. PLEASE CHECK YOUR SPAM MAILBOX IF YOU DO NOT RECEIVE NOTIFICATION FROM CAMP DOCS TO UPLOAD YOUR FILES INTO THE PORTAL. REGISTRANTS SHOULD START RECEIVING NOTIFICATON FROM CAMP DOCS FOR PAPERWOK IN APRIL.**

The Massachusetts Department of Public Health has mandated that the following paperwork be on file for each camper.

*Please be aware your camper is required to meet the Massachusetts State Requirements for immunization regardless of the state or country your camper is from. Please make sure to fill in each date of each immunization dose if it is not included on the physical form.*

**Celtics Camps Registration Checklist!**

1. \_\_\_\_\_\_\_\_\_ “PAGE 1 Personal and Health History Form” completed with the **Camp Location AND Week Attending** clearly noted. (Example: BSC Waltham, July 20-24) ***\*REQUIRED\****
2. \_\_\_\_\_\_\_\_\_ A physical within the past 18 months. ***\*REQUIRED\****
3. \_\_\_\_\_\_\_\_\_ Complete immunization record **with every date of each dose of required immunizations documented**. (Unless included on MD physical) ***\*REQUIRED\****
4. \_\_\_\_\_\_\_\_\_ Signed Waivers and Releases ***\*REQUIRED\****
5. \_\_\_\_\_\_\_\_\_ Signed Camper Pick Up Form ***\*REQUIRED\****
6. \_\_\_\_\_\_\_\_\_ AUTHORIZATION TO ADMINISTER MEDICATION (If camper requires rescue meds like albuterol or EpiPen) ***\*ONLY REQUIRED FOR CAMPERS WITH MEDICATIONS AT CAMP\****

**PLEASE BRING MEDICAITON IN PHARMACY LABELED CONTAINER ON THE FIRST DAY OF CAMP.**

If you have any questions, please feel free to e-mail the camp nurse at [celticscampnurse@gmail.com](mailto:celticscampnurse@gmail.com)

Thank you,

Jamie Benoit, RN, Camp Nurse

**CELTICS CAMPS CELTICS CAMP NURSE:** [**celticscampnurse@gmail.com**](http://celticscampnurse@gmail.com)

[www.celtics.com/camps](http://www.celtics.com/camps)

**PAGE 1**

**Personal and Health History Form**

(This form to be completed by parent of minors or by staff members themselves)

Camper’s Name: **Camp Location/Week Attending:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First Initial

Birthday: \_\_\_/\_\_\_/\_\_\_ Gender: \_\_\_\_ Age: \_\_\_\_ Parent or Guardian (or Spouse) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: . Home Ph: .

Street& Number City State Zip

Bus. Address: . Bus. Pn: .

Street& Number City State Zip

Second Parent of Guardian or Emergency Contact: .

Home Address: . Home Ph: .

Street& Number City State Zip

Bus. Address: . Bus. Pn: .

Street& Number City State Zip

If not available in an emergency notify:

Name: . Home Ph: .

Address: .

Street& Number City State Zip

**Health History**

**Check/Give approximate Dates**

Frequent Ear Infection **Diseases Allergies**

Heart Defect/Disease Mumps Ivy Poisoning

Convulsions Chicken Pox Hay Fever

Diabetes Measles Insect Stings

Bleeding/Clotting Disorders German Measles Penicillin

Hypertension Other Drugs

Mononucleosis Asthma

Other (specify)

Operations or serious injuries (dates)

Chronic or recurring illness or medical condition

Dietary Restrictions

Current Medications (send with instructions)

Other Diseases

Name of Dentist/Orthodontist Phone:

Name of Family Physician Phone:

Do you carry family medical/hospital insurance? Yes No

If so, indicate: Carrier: Policy or Group#:

**IMPORTANT- THIS BOX MUST BE COMPLETED AND SIGNED FOR ATTENDANCE**

**Authorization for Treatment**: This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child’s health record from providers who treat my child and these providers may talk with the program’s staff about my child’s health status.

Signature of Parent/ Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Camper:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*If for religious reasons, you cannot sign this the camp should be contacted for a legal waiver which must be signed for attendance.

Date:

**PAGE 2**

**PERSONAL HEALTH AND HISTORY FORM**

**Health Care Recommendations by Licensed Physician:**

**I have examined the above applicant within the past 18 months. Date examined:**

In my opinion, the above’s condition does does not preclude his/her participation in an activity camp program.

Height: Weight: Blood Pressure:

The applicant is under the care of a physician for the following condition(s):

Current Treatment (include current medications):

Explanation of any reported loss of consciousness, convulsion, or concussion:

Does applicant have epilepsy? Yes No Does he/she have diabetes Yes No

**Recommendations and Restrictions while at Camp**

Any treatment to be continued at camp

Any medication to be administered at camp (specific dosages)

Any dietary restrictions

Any allergies (food, drugs, plants, insects, etc.)

Activities to be encouraged or limited

Additional health information

Licensed Physician’s Signature:

Address: Phone:

Street & Number City State ZIP

Date of Form Completion: By:

\*Initial if completed by nurse or assistant

**PAGE 3 Required Immunizations: (A MD signed physical with immunizations is acceptable in lieu of this form)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Immunization | Dose | Dose | Dose | Dose | Dose |
| DTaP  **5 doses;** 4 doses are acceptable if the 4th dose is given on or after the 4th birthday. DT is only acceptable with a letter stating a medical contraindication to DTaP | 1. | 2. | 3. | 4. | 5. |
| Tdap (**12 years old, and/or 7th grade or older)1 dose;** and history of DTaP primary series or age appropriate catch-up vaccination. Tdap given at ≥7 years may be counted, but a dose at age 11-12 is recommended if Tdap was given earlier as part of a catch-up schedule. Td should be given if it has been ≥10 years since Tdap. | 1. |  |  |  |  |
| Polio  **4 doses;** 4th dose must be given on or after the 4th birthday and ≥6 months after the previous dose, or a 5th dose is required. 3 doses are acceptable if the 3rd dose is given on or after the 4th birthday and ≥6 months after the previous dose. | 1. | 2. | 3. | 4. |  |
| Hepatitis B  **3 doses** | 1. | 2. | 3. |  |  |
| Varicella  **2doses** | 1. | 2. |  |  |  |
| MMR:  **2doses;** first dose must be given on or after the 1st birthday and the 2nd dose must be given ≥28 days after dose 1; laboratory evidence of immunity acceptable | 1. | 2. |  |  |  |
| NOT MANDATORY:  COVID  Please circle one if applicable:  Moderna  Pfizer  Johnson and Johnson | 1. | 2. | Booster |  |  |

\* A reliable history of chickenpox includes a diagnosis of chickenpox, or interpretation of parent/guardian description of chickenpox, by a physician, nurse practitioner, physician assistant or designee.

†Medical exemptions (dated statement signed by a physician stating that a vaccine(s) are medically contraindicated for a student) and religious exemptions (dated statement signed by a student or parent/guardian, if the student is <18 years of age, stating that a vaccine(s) are against sincerely held religious beliefs)

****

CAMPER PICK UP FORM

I give permission for the following people to pick up

(Camper’s Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

at the end of the camp day.

There must be two people available to pick up camper.

Name Relationship to Camper

|  |  |
| --- | --- |
| 1. |  |
| 2. |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

Parent Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WAIVER, RELEASE AND ASSUMPTION OF RISK**

In consideration of the opportunity afforded me to participate on a voluntary basis in various activities, which may include but are not limited to basketball drills and games (the “Activities”) at Celtics Camps, on behalf of myself, my personal representatives, heirs, next of kin, successors and assigns, I hereby forever:

1. voluntarily waive, release and discharge Campco JA, LLC, Banner Seventeen, LLC (doing business as the Boston Celtics), Boston Celtics Shamrock Foundation, Inc., the National Basketball Association and its Member Teams, NBA Properties, Inc., and their respective officers, directors, unit holders, members, shareholders, agents, parents, subsidiaries, affiliates, successors and assigns (including, but not limited to, any agencies, broadcasters, periodicals or publications) and employees (each in their individual and corporate capacities) (collectively, the “Released Parties”) from any and all liability, actions, causes of action or claims for personal injury, death, disability, property theft, property damage or claims of any nature, whether in law or equity, known or unknown, which I may have or which may subsequently accrue to me or my estate as a result of my participation in the Activities; and
2. agree to defend, indemnify and hold harmless the Released Parties from and against any and all actions, causes of actions, claims, demands, liabilities, losses, damages, costs and expenses (including reasonable attorney’s fees) arising out of my participation in the Activities, even though the liability may arise out of negligence on the part of the entities or persons mentioned above, or otherwise.

I understand that I could be injured while participating in the Activities. I also understand that there are potential risks of which I may not presently be aware. I recognize the importance of, and agree to fully comply with, any applicable laws, policies, rules, and regulations, and any instructions regarding participation in the Activities. I also certify that I am in good condition and am able to safely participate in the Activities, which may include playing, assisting or otherwise engaging in the sport of basketball as an active participant, assistant or spectator during such special events for which I have volunteered.

I voluntarily elect to participate in the Activities with the knowledge of the potential risks involved in the Activities, and hereby agree to accept and assume full responsibility for and risk of personal injury, death and property damage resulting from my participation in the Activities. I acknowledge that I have read this document thoroughly and am fully aware of the legal consequences of signing below and that I sign the same as my own free act and deed. I agree that if any portion of this document is held invalid, the remainder will continue in full legal force and effect.

Please check one:

\_\_\_\_\_ I am 18 years of age or older, I have read the foregoing and I fully and completely understand and agree to the contents of it, and I sign the same as my own free act and deed.

\_\_\_\_\_ I represent that the Participant is a minor, that I am the parent or legal guardian of the minor and that I have read the foregoing, fully and completely understand and agree to the contents of it, and I sign the same as my own free act and deed on behalf of myself and the Participant.

Name of Participant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Parent or Guardian (if Participant is a minor): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Participant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email (of Parent or Guardian\*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone (of Parent or Guardian\*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (of Parent or Guardian\*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent or Guardian (if Participant is a minor): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Participant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Enter your own information if you are the Participant and you are 18 years of age or older; enter your own information if the Participant is 17 years of age or younger and you are his or her parent or legal guardian

**RELEASE AND AUTHORIZATION FOR USE OF PHOTOGRAPHS, RECORDING(S), AND NAME**

For valuable consideration, the receipt of which is hereby acknowledged, in connection with my participation in the Activities, I hereby grant Campco JA, LLC, Banner Seventeen, LLC (doing business as the Boston Celtics), Boston Celtics Shamrock Foundation, Inc., the National Basketball Association and its Member Teams, NBA Properties, Inc., and their respective parents, subsidiaries, affiliates, successors and assigns (collectively, the “NBA Parties”), the following worldwide, irrevocable rights in connection with any and all photographs, videos, and other recordings taken of me:

1. to use, re-use, publish, and re-publish, without my prior approval, any and all photographs, videos, and other recordings taken of me, in whole or in part, individually or in conjunction with other photographs, videos, or other recordings, modified or altered, in any medium, manner or form and for any purpose whatsoever, including, without limitation, all promotional, trade and advertising uses;
2. to use my name in connection therewith, if any NBA Party so desires; and
3. to copyright such recording(s) in the Boston Celtics name or any other name chosen by any NBA Party.

I hereby waive any right that I may have to inspect and/or approve the finished product of such recording(s) or the advertising copy that may be used in connection therewith, or the use in which it might apply. Additionally, I waive any right to royalties or other compensation arising or related to the use of such recording(s).

On behalf of myself, my personal representatives, heirs, next of kin, successors and assigns, I hereby waive, release and discharge, and agree to defend, indemnify and hold harmless, the Released Parties and their duly authorized agents from all liabilities, claims (including, but not limited to, any claims for invasion of privacy or defamation), complaints, demands, actions, damages, costs or expenses (including attorneys’ fees and costs) of any nature, whether in law or equity, known or unknown, which I may have, or which may subsequently accrue to me or my estate, against any of the Released Parties arising out of or in any way related to the use of such recording(s) as authorized herein.

I agree not to transmit, distribute or sell (or aid in transmitting, distributing or selling), in any media now or hereafter existing, any description, account, picture, video, audio or other form of exploitation or reproduction of the Activities or any surrounding activities (in whole or in part). I also agree not to publicly share any not-otherwise-publicly-accessible information about the Activities or the surrounding activities, by any means, without the Boston Celtics’ prior written consent. I will not disclose any such details on the Internet (including blogs, social media sites, or any other website), through any media outlet (including newspapers, magazine, television, radio, or any other media outlet), or via any other medium likely to reach a wide audience.

Please check one:

\_\_\_\_\_ I am 18 years of age or older, I have read the foregoing and I fully and completely understand and agree to the contents of it, and I sign the same as my own free act and deed.

\_\_\_\_\_ I represent that the Participant is a minor, that I am the parent or legal guardian of the minor and that I have read the foregoing, fully and completely understand and agree to the contents of it, and I sign the same as my own free act and deed on behalf of myself and the Participant.

Signature of Parent or Guardian (if Participant is a minor): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Participant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\* \* \*

**FOLLOWING PAGE TO BE COMPLETED IF THE PARTICIPANT IS A MINOR (under the age of 18)**

**OR OTHERWISE SUBJECT TO THE CARE OF A LEGAL GUARDIAN**

**TO BE COMPLETED IF THE PARTICIPANT IS A MINOR (under the age of 18)**

**OR OTHERWISE SUBJECT TO THE CARE OF A LEGAL GUARDIAN**

As a parent or legal guardian for the above stated Participant, I acknowledge that I HAVE READ AND FULLY UNDERSTAND the above Release and Indemnity Agreement, and I hereby agree to all of its items and adopt the same as my statement on behalf of my minor child or ward. I also hereby give my consent to his or her participation in the Activities. Furthermore, in consideration of the Released Parties permitting the participation of the Participant in the Activities, I hereby agree to indemnify, defend and hold the Released Parties harmless from and against any and all losses, damages, costs or expenses (including attorneys’ fees and other costs of defense) which any of them may sustain as a result of, or in connection with, the Participant’s participation in the Activities, regardless of whether it arises as a result of injury or loss caused by the negligence or fault of the Released Parties.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Parent or Guardian (Please Print) Signature of Parent or Guardian Date

The following pages are medication permission forms. If you have a camper who receives meds at camp Massachusetts State Law requires that you fill out one form for each med, with ALL the information that we are asking to be included on the form with your signature.

**\*\*\*\*If you do not have a camper on prescription medications that will be given at camp, you can ignore the following pages. \*\*\*\*\*\***

**MEDICATION ADMINISTRATION INFORMATION:**

**Per Massachusetts State Law:** ***Please make sure the meds you send to camp are in* *original pharmacy labeled boxes with your camper’s name, and the directions for administration are legible. We do not accept medication that does not have a pharmacy label.***

All parts of this must be filled out.

**Please DO NOT write “see Asthma Action Plan” or “see Allergy Action Plan”, the completed and signed parent permission forms are required in addition to the Action Plans.**

**For Inhalers:** You must include how many puffs, and how frequently inhalation is to be given per the MD order: **Example:** 2 puffs every 4 hours for Shortness of Breath

**For Benadryl:** You must include the dosage and amount of medication to be given for that dosage

**Example:** 25 mg, 2 tsp., as needed for mild allergic reaction.

**EpiPen:** You must include the dosage of the EpiPen

**Example:** EpiPen Jr 0.15 mg, 1 injection in thigh for anaphylaxis OR

EpiPen, 0.3 mg, 1 injection in thigh for anaphylaxis

The duration of the order is the week of camp from the first day attending to the last day attending.

**Please make copies of this form and bring the original with you to camp on the first day your camper attends camp.**

Thank you for your anticipated cooperation in this matter.

Jamie Benoit, RN

Camp Nurse

**In Reference to the page below:**

Health Care Consultant at a recreational camp is a Massachusetts licensed physician certified nurse practitioner or a physician assistant with documented pediatric training. Health Care Supervisor is a staff person of a recreational camp for children who is 18 years old or older and is responsible for the day to day operation of the health program or component, and is a Massachusetts licensed physician, physician assistant, certified nurse practitioner, registered nurse, licensed practical nurse, or other person specially trained in first aide.

**AUTHORIZATION TO ADMINISTER MEDICATION TO A CAMPER (Completed by Parent/Guardian)**

Camper’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Camper’s Age\_\_\_\_\_\_\_\_\_\_\_\_\_

Camper’s Food/Drug Allergies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent Emergency Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent Business Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prescribing Doctor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Duration of Order: (dates camper will be attending camp) **From**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **To** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Medicaiton\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dose of Medication (how many milligrams)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Amount of Medication to be given (how many pills, injections or teaspoons)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Route Of medication (Circle One): by mouth, by injection in muscle, by inhaler

Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Possible Side Effects or Adverse Reactions\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Storage Requirements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Location where medication administration will occur: With athletic trainer

I hereby authorize the health care consultant or properly trained health care supervisor at Celtics Basketball

Camp to administer to my child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(name of camper)

the medication listed above in accordance with 105 CMR 430.160C and 105 CMR 430.160D

**If above medication includes epinephrine injection system:**

I hereby authorize my child to self-administer, under supervision of the health care supervisor (circle one): yes no not applicable

**If the above listed medication includes insulin for diabetic management:**

I hereby authorize my child to self-administer, under the supervision of a parent with the approval of the health care consultant (circle one) : yes, no not applicable

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

**AUTHORIZATION TO ADMINISTER MEDICATION TO A CAMPER (Completed by Parent/Guardian)**

Camper’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Camper’s Age\_\_\_\_\_\_\_\_\_\_\_\_\_

Camper’s Food/Drug Allergies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent Emergency Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent Business Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prescribing Doctor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Duration of Order: (dates camper will be attending camp) **From**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **To** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Medicaiton\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dose of Medication (how many milligrams)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Amount of Medication to be given (how many pills, injections or teaspoons)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Route Of medication (Circle One): by mouth, by injection in muscle, by inhaler

Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Possible Side Effects or Adverse Reactions\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Storage Requirements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Location where medication administration will occur: With athletic trainer

I hereby authorize the health care consultant or properly trained health care supervisor at Celtics Basketball

Camp to administer to my child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(name of camper)

the medication listed above in accordance with 105 CMR 430.160C and 105 CMR 430.160D

**If above medication includes epinephrine injection system:**

I hereby authorize my child to self-administer, under supervision of the health care supervisor (circle one): yes no not applicable

**If the above listed medication includes insulin for diabetic management:**

I hereby authorize my child to self-administer, under the supervision of a parent with the approval of the health care consultant (circle one) : yes, no not applicable

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

**AUTHORIZATION TO ADMINISTER MEDICATION TO A CAMPER (Completed by Parent/Guardian)**

Camper’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Camper’s Age\_\_\_\_\_\_\_\_\_\_\_\_\_

Camper’s Food/Drug Allergies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent Emergency Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent Business Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prescribing Doctor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Duration of Order: (dates camper will be attending camp) **From**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **To** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Medicaiton\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dose of Medication (how many milligrams)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Amount of Medication to be given (how many pills, injections or teaspoons)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Route Of medication (Circle One): by mouth, by injection in muscle, by inhaler

Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Possible Side Effects or Adverse Reactions\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Storage Requirements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Location where medication administration will occur: With athletic trainer

I hereby authorize the health care consultant or properly trained health care supervisor at Celtics Basketball

Camp to administer to my child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(name of camper)

the medication listed above in accordance with 105 CMR 430.160C and 105 CMR 430.160D

**If above medication includes epinephrine injection system:**

I hereby authorize my child to self-administer, under supervision of the health care supervisor (circle one): yes no not applicable

**If the above listed medication includes insulin for diabetic management:**

I hereby authorize my child to self-administer, under the supervision of a parent with the approval of the health care consultant (circle one) : yes, no not applicable

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