



## 2012 TAYC Junior Sailing Program Health Information Forms

All pages **MUST** be completed with a parent/guardian signature.

**ONE SET OF FORMS PER JR. SAILOR**

### I. CONTACT INFORMATION

Course Name: \_\_\_\_\_ Dates of Course: \_\_\_\_\_

Jr. Sailor's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Gender: Male \_\_\_ Female \_\_\_ Hair Color: \_\_\_\_\_

Eye Color: \_\_\_\_\_ Age: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Parent/Guardian Cell Phone #: \_\_\_\_\_

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

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

***If neither of the above is available in an emergency, notify:***

Name: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

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

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

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

Parent/Guardian Name or Emergency Contact Name: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_

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

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

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

**Primary Care Physician/Clinic Phone #: \_\_\_\_\_**

**II. JUNIOR SAILOR INFORMATION**

Please include a copy of your child's UP TO DATE immunization record AND Sign below. If the immunization record is not available please complete the following and sign below. Parents may also check with doctor/school to receive a copy.

- **Kindergarten - Grade 4:** 4 DTaP/DTP; 4 Polio; 2 Measles; 2 Mumps; 2 Rubella; 2 Chickenpox (Varicella) or proof of disease; and 3 Hepatitis B; 2 Hepatitis A; 4 HiB
- **Grades 5 - 12:** 4 DTaP; 1 Tdap; 4 Polio; 2 Measles; 2 Mumps; and 2 Rubella

**Name of Immunization Date(s) Given**

DTap/DTP (series of 4 shots) \_\_\_\_\_

Hepatitis B (series of 3 shots) \_\_\_\_\_

HiB (series of 4 shots) \_\_\_\_\_

Polio/OVP (series of 4 shots) \_\_\_\_\_

MMR (Measles, Mumps, Rubella) (series of 2 shots) \_\_\_\_\_

Tdap or Tetanus Booster \_\_\_\_\_

Hepatitis A (For select populations; 2 shots) \_\_\_\_\_

Vericella vaccine (series of 2 shots) \_\_\_\_\_ or Chicken pox infection \_\_\_\_\_ (month/year infected)

Is your child exempt from any immunization? No \_\_\_\_ Yes \_\_\_\_ (check one) \_\_\_\_\_ religious objection  
 \_\_\_\_\_ medical contraindication

*(If your child is exempt based on medical contraindication, please provide the medical exemption letter, written by a licensed physician in Maryland.)*

**I verify that this information is accurate and current to the best of my knowledge.**

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

**III. HEALTH INFORMATION**

**Are there any special dietary needs?**

\_\_\_\_\_

**Are there any allergies?**

Food \_\_\_\_\_ Medicines \_\_\_\_\_ Environment \_\_\_\_\_ Other \_\_\_\_\_

Has this jr. sailor ever required any psychiatric counseling or hospitalization? No \_\_\_\_ Yes \_\_\_\_

If so, please explain:

\_\_\_\_\_

Has junior sailor had any major operations/hospitalization/illnesses?

\_\_\_\_\_

Please provide any pertinent information about the junior sailor's behavior and physical, emotional, or mental health, which the junior program should be aware of. *Attach additional paper if needed.*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

The Health Care Provider will administer the following over the counter medicines or the generic equivalents as specified below. Dosages will be administered according to the directions on the container. Except for acetaminophen and topical medicines, only one dose of a nonprescription medicine is given unless the junior sailor's health practitioner approves an additional dose in writing.

Symptom	Medication	Symptom	Medication
Minor aches/pain/fever	Acetaminophen/ibuprofen	Minor cough/Sore throat	Cough drops
Minor allergic reactions/allergies	Diphenhydramine	Poison Ivy/Rashes	Calagel Lotion
Diarrhea	Kaopectate	Bug Bites	Benzocaine Swabs
Indigestion/heartburn	Antacid	Motion sickness (WR)	Dramimine/Dimenhydrinate
Constipation	Milk of Magnesia	Jelly Fish Stings (WR)	Vinegar/meat
Clogged Ears	Auro-Dry		tenderizer/Baking
			soda/hydrocortisone cream/
			Solarcaine/Lidocaine Spray

**IV. MEDICAL INFORMATION**

Bring enough medication to last the entire sailing course. All meds must meet the following guidelines:

- All prescription and non-prescription medication will have a physician's signed order fully completed; one per medication (see page 5).
- All Prescription medication will be in original container labeled by the pharmacist or physician with:

*Name of junior sailor Name of medication Dosage, route and time of administration*

*Name of physician Prescription date and expiration date Conditions for storage*

- All Non-Prescription medication will be in the original sealed container with the label intact.

Jr. Sailor's name will be put on the container in a position that does not obscure the label.

- All medications will be brought to the junior sailing program by an adult and turned into the Junior Program Nurse/Health Aide.
- Parents will be contacted if a question arises about your child's medication.
- All medications must have been administered at least once at home with no problems.
- Emergency medications (Inhalers, Epipens, etc.) must also have pharmacy label. The immediate instructor may keep those that need to be closer to the junior sailor. In order to use emergency medication junior sailor must be able to self-administer and parents have given permission as signed below. However, a second set of medication must be brought to the Junior Program Nurse/Health Aide.

Check here \_\_\_\_\_ if this junior sailor takes **NO** medications on a routine basis. (still sign below)

Are there any medications taken during the school year that the junior sailor does/may not take during the summer?

No \_\_\_\_\_ Yes \_\_\_\_\_ If so, please give name of medication: \_\_\_\_\_

\_\_\_\_\_

Please sign and date to verify that you have given permission for the Junior Program Nurse/Health Aide to administer the medications designated to your child.

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

**V. SELF-ADMINISTRATION OF MEDICATIONS**

According to the State of MD: Self-Administration of medications means the act of a junior sailor ingesting, injecting or applying the junior sailor's own nonprescription or prescription medicine when the individual identifies their own medicine and follows the directions for use including the correct route or dosage.

**If junior sailors are allowed to self-administer medications during the junior sailing program:**

- All medications will be turned in to the Junior Program Nurse/Health Aide and kept securely,
- At the prescribed time junior sailors will be handed their medication bottle/container and dispense the medication from the containers themselves. This is all done under the supervision of the junior sailing program medical staff or director.

If there are situations where the junior sailor is not able to self-administer medications and they are to participate in an off site activity, please call the Office (410-226-5269).

I give permission for my child to self-administer the medication as listed according to package or doctor's directions. I acknowledge that my child has previously self-administered these medications at home under my supervision and has shown understanding and responsibility to do so at the junior sailing program. I understand the definition of self-administer and am aware that all medications will be taken in the presence of the Junior Program Nurse, Health Aide or Director.

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



**PHYSICIAN'S SIGNED ORDER FOR MEDICATION AT SUMMER CAMP**  
**ONLY ONE MEDICATION PER FORM**

Junior Sailor Name: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_ (tabs, mg,ml,ml/tsp, # of puffs)

Route: \_\_\_\_\_ Time of Administration: Breakfast Lunch Dinner Other \_\_\_\_\_

If PRN, for what symptoms? \_\_\_\_\_

How Often? \_\_\_\_\_

List any precautions personnel should know of or any unusual effects that might be observed.

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

Services should begin (Date): \_\_\_\_\_ and terminate (Date): \_\_\_\_\_

\_\_\_\_\_ Junior Sailor is **able** to self-administer this medication. *For inhaler, Epi-pen and insulin, it has been determined that this student has been trained in its use, including knowing when the medication is to be used.*

\_\_\_\_\_ Junior Sailor is **not able** to self-administer this medication.

Physician's Name Printed: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Physician's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
*(no signature stamps please)*

Office Address: \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_