Hello, Welcome to Jr. Celtics Academy Camps!

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

YOUR CAMPER'S MEDICAL PAPERWORK IS DUE WITHIN TWO WEEKS OF ONLINE REGISTRATION. REGISTRATION IS INCOMPLETE UNTIL MEDICAL PAPERWORK IS ACCEPTED.

- **IF REGISTERING AFTER MAY 1: Paperwork is due upon online registration.**

PLEASE UPLOAD ALL REQUESTED DOCUMENTS TO THE DROPBOX LINK PROVIDED IN LEAGUE APPS.

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.

Jr. Celtics Academy Camps Registration Checklist!

1. _____ "PAGE 1 Personal and Health History Form" completed with the **Camp Location AND Week Attending** clearly noted. (Example: TRACK, June 23-27) ***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 Camper Pick Up Form ***REQUIRED***

5. _____ 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 nurse@celtics.com

Thank you,
Jr. Celtics Academy

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

	Diseases	**Allergies**
_____ Frequent Ear Infection	_____ Mumps	_____ Ivy Poisoning
_____ Heart Defect/Disease	_____ Chicken Pox	_____ Hay Fever
_____ Convulsions	_____ Measles	_____ Insect Stings
_____ Diabetes	_____ German Measles	_____ Penicillin
_____ Bleeding/Clotting Disorders		_____ Other Drugs
_____ Hypertension		_____ Asthma
_____ Mononucleosis		_____ 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:

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)

Meningococcal Disease and Camp Attendees: Commonly Asked Questions

What is meningococcal disease?

Meningococcal disease is caused by infection with bacteria called *Neisseria meningitidis*. These bacteria can infect the tissue (the "meninges") that surrounds the brain and spinal cord and cause meningitis, or they may infect the blood or other organs of the body. Symptoms of meningococcal disease may appear suddenly. Fever, severe and constant headache, stiff neck or neck pain, nausea and vomiting, and rash can all be signs of meningococcal disease. Changes in behavior such as confusion, sleepiness, and trouble waking up can also be important symptoms. In the US, about 350-550 people get meningococcal disease each year and 10-15% die despite receiving antibiotic treatment. Of those who survive, about 10-20% may lose limbs, become hard of hearing or deaf, have problems with their nervous system, including long term neurologic problems, or have seizures or strokes. Less common presentations include pneumonia and arthritis.

How is meningococcal disease spread?

These bacteria are passed from person-to-person through saliva (spit). You must be in close contact with an infected person's saliva in order for the bacteria to spread. Close contact includes activities such as kissing, sharing water bottles, sharing eating/drinking utensils or sharing cigarettes with someone who is infected; or being within 3-6 feet of someone who is infected and is coughing and sneezing.

Who is most at risk for getting meningococcal disease?

People who travel to certain parts of the world where the disease is very common, microbiologists, people with HIV infection and those exposed to meningococcal disease during an outbreak are at risk for meningococcal disease. Children and adults with damaged or removed spleens or persistent complement component deficiency (an inherited immune disorder) are at risk. Adolescents, and people who live in certain settings such as college freshmen living in dormitories and military recruits are at greater risk of disease from some of the serotypes.

Are camp attendees at increased risk for meningococcal disease?

Children attending day or residential camps are **not** considered to be at an increased risk for meningococcal disease because of their participation.

Is there a vaccine against meningococcal disease?

Yes, there are 2 different meningococcal vaccines. Quadrivalent meningococcal conjugate vaccine (Menactra and Menveo) protects against 4 serotypes (A, C, W and Y) of meningococcal disease. Meningococcal serogroup B vaccine (Bexsero and Trumenba) protects against serogroup B meningococcal disease, for age 10 and older.

Should my child or adolescent receive meningococcal vaccine?

That depends. Meningococcal conjugate vaccine is routinely recommended at age 11-12 years with a booster at age 16. In addition, these vaccines may be recommended for children with certain high-risk health conditions, such as those described above. Otherwise, meningococcal vaccine is **not** recommended for attendance at camps.

Meningococcal serogroup B vaccine (Bexsero and Trumenba) is recommended for people with certain relatively rare high-risk health conditions (examples: persons with a damaged spleen or whose spleen has been removed, those with persistent complement component deficiency (an inherited disorder), and people who may have been exposed during an outbreak). Adolescents and young adults (16 through 23 years of age) who do not have high risk conditions **may** be vaccinated with a serogroup B meningococcal vaccine, preferably at 16 through 18 years of age, to provide short term protection for most strains of serogroup B meningococcal disease. Parents of adolescents and children who are at higher risk of infection, because of certain medical conditions or other circumstances, should discuss vaccination with their child's healthcare provider.

How can I protect my child or adolescent from getting meningococcal disease?

The best protection against meningococcal disease and many other infectious diseases is thorough and frequent handwashing, respiratory hygiene and cough etiquette. Individuals should:

1. wash their hands often, especially after using the toilet and before eating or preparing food (hands should be washed with soap and water or an alcohol-based hand gel or rub may be used if hands are not visibly dirty);
2. cover their nose and mouth with a tissue when coughing or sneezing and discard the tissue in a trash can; or if they don't have a tissue, cough or sneeze into their upper sleeve.
3. not share food, drinks or eating utensils with other people, especially if they are ill.
4. contact their healthcare provider immediately if they have symptoms of meningococcal disease.

If your child is exposed to someone with meningococcal disease, antibiotics may be recommended to keep your child from getting sick.

You can obtain more information about meningococcal disease or vaccination from your healthcare provider, your local Board of Health (listed in the phone book under government), or the Massachusetts Department of Public Health Division of Epidemiology and Immunization at (617) 983-6800 or on the MDPH website at www.mass.gov/dph.

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 _____

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: _____