

**Daisy Recreation Program
350 Dunhams Corner Road
East Brunswick, NJ 08816
(732) 390-6797**

**Medical Record and Physical Examination for Staff,
Counselors-In-Training, and Volunteers**

Date _____

Name _____ Date of Birth _____

Address _____ Age _____ Sex _____

City and State _____ Telephone _____

In Emergency Notify:

Name _____ Relationship _____

Address _____ Home Telephone _____

Medical Information

Please indicate with a check in the individual has or is subject to any of the following. Please give details below

- | | | |
|---|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart Trouble |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Fainting | <input type="checkbox"/> Wears Contact Lens |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Other Condition |
| <input type="checkbox"/> Grand Mal Seizures | <input type="checkbox"/> Petit Mal Seizures | |

*Please explain: _____

Restrictions: _____

Immunizations	Month/Year		Diseases	Had Vaccination	Had Disease
Tetanus			Measles		
Diphtheria			Mumps		
Polio			Rubella		
Whooping Cough					
Chicken Pox					

- Is the individual now under medical care or taking any medication? _____
- Has there been any surgery, injury, illness, allergy or change in health status since last physical examination? _____

If "Yes" please explain:

The Daisy Recreation Program nurse has my permission to administer the following over the counter medications according to label instructions:

Pepto Bismol _____ Yes _____ No _____ Tylenol Caplets _____ Yes _____ No _____

Date (Parent/Guardian Signature) (Staff Member Signature)

Parent's Statement: To the best of my knowledge, the information is correct and complete. I know of no reason to restrict the individuals activity, and give my permission for him/her to participate in all activities except as specifically noted under restrictions.

Date (Parent/Guardian Signature) (Staff Member Signature)

To Be Completed By Physician

Please note: the individual must have a Mantoux Tuberculin Skin Test (no other test may be substituted for the Mantoux Tuberculin Skin Test). This test must be given within ONE YEAR prior to beginning work at the Daisy Recreation Program. If you have tested positive to previous Mantoux Tuberculin Skin Tests or the one just taken, you will need to have a chest x-ray taken and read by a physician and provide documentation that you do not have any active lesions. Please indicate the date of this test and the results on this form.

Mantoux Tuberculin Skin Test: Given _____ Results _____
(Date) (Positive/Negative)

Medical Examination

Please note: this medical examination must have been completed within the SIX MONTHS preceding the first day of the Daisy Recreation Program.

PHYSICIAN'S OFFICE STAMP



Height	
Weight	
Pulse	
Blood Pressure	
Vision	
Glasses (Y/N)	
Hearing	

*The individual whose name appears on this form is in good health and is free from chronic or recurrent communicable disease. I know of no reason to restrict the individual's activity except as noted above.

Please print: Date of Physical Examination _____

Physician's name _____

Address _____ Telephone _____

Physician's Signature _____

08-02-09

**DAISY RECREATION PROGRAM
PHYSICIAN & EMPLOYEE/STAFF AUTHORIZATION FORM
FOR SELF-ADMINISTRATION OF ASTHMA INHALER**

**Part I: Employee/Staff Member Authorization
(and Parent/Guardian if employee is under 18 years of age)**

Employee/Staff name _____ Date of Birth _____ Age _____

- I understand that all medications must be labeled with the name of the medication, name of employee/staff member, name of physician, date and directions for administration.

Employee signature
(or parent/guardian if employee is under 18 years of age)

Date

- I give permission for my child to carry and self medicate with the prescribed medicine.

Parent/Guardian Signature

Date

Part II: Physician Authorization (to be completed by physician)

Employee/Staff name _____

The above named individual is capable of self medication: _____ YES _____ NO

1. Name and strength of inhaler _____
2. Reason for medication _____
3. Route of administration _____
4. Dosage of medication _____
5. Time and frequency _____
6. Side effects _____

Signature of Physician

Date

PHYSICIAN'S OFFICE STAMP REQUIRED HERE



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Township of East Brunswick

DIVISION OF RECREATION
AND COMMUNITY SERVICES

DAISY RECREATION PROGRAM EMPLOYEE/STAFF

AUTHORIZATION FOR ADMINISTRATION OF EPINEPHRINE

The Township of East Brunswick, Division of Recreation requires written permission from employee/staff member in order for staff to administer emergency prescribed epinephrine during program time.

The medication can be administered in an emergency situation only by Division staff members who have been trained by a health care professional.

A written authorization from the employee (or employee's parent if under 18 years of age) is required. Please complete the form below:

Emergency Care for Anaphylaxis Employee Authorization

- I authorize the trained Division of Recreation staff to administer epinephrine to _____ in an emergency situation as prescribed by _____
(Employee/Staff member)
(Doctor's Name) _____
- East Brunswick Township and its employees shall have no liability as a result of any injury arising from the administration of (Medication) _____
_____ to _____
- The employee shall indemnify and hold harmless the Township, their agents or Division of Recreation staff from any and all claims arising out of the administration of (Medication) _____

Notary

Employee Signature

(Parent/Guardian if Employee is under 18 years of age)

Date

Date

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Township of East Brunswick

DIVISIONS OF RECREATION
AND COMMUNITY SERVICES

DAISY RECREATION PROGRAM EMPLOYEE/STAFF

PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF EPINEPHRINE

The Township of East Brunswick, Division of Recreation requires written permission from an employee/staff member's physician in order for staff to administer emergency prescribed epinephrine during program time.

The medication can be administered in an emergency situation only by Division of Recreation staff members who have been trained by a health care professional.

A written authorization from the prescribing physician stating dosage, directions and listing of possible side effects is also required. All medical conditions and allergies must also be listed.

Please have your physician complete the form below:

Emergency Care for Anaphylaxis Physician Authorization and Medication Orders

1. I am a licensed physician with offices located at _____

2. I hereby certify that _____, age _____ is allergic to _____
_____ and has the following other conditions _____

He/She is my patient and may require the administration of epinephrine for anaphylaxis while working for the Daisy Recreation Program

- () He/She has been trained and has the capability for self-administration of this medication.
- () In the event he/she becomes unable to self-administer this medication I authorize the Daisy Nurse or non-health professional who has been trained in this procedure to administer epinephrine for anaphylaxis.

3. EPI Pen

- _____ Give the pre-measured dose of 0.3 mg. Epinephrine 1:1000 aqueous solution (0.3cc)**
- _____ Repeat dose in 15 minutes if rescue squad has not arrived (two kits will be needed at the Daisy Program)

** When an EPI Pen is administered at the Daisy Program, 911 will be called and the employee transported to the nearest medical facility

What symptoms will be present for the EPI pen to be administered? _____

What side effects should be expected? _____

Physician's Name

Physician's Signature

Date

Telephone

Physician's Office Stamp 

PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF EPINEPHRINE 08-06-09