

American Heritage Summer Day Camp Camper Medical Form

In order for our Camp Staff to properly care for your child we ask that this form be completed on both sides.
Please use a **BALL POINT PEN** and **PRINT** • This form **MUST** be completed and returned no later than **May 1, 2008.**

This information will be filed in the Camp Office with the Camp Nurse

The **REVERSE SIDE** of this form **MUST** be completed by Camper's Physician: ***Physician Authorization***

Camper Attending: Sess I___ Sess II___ Sess III___ Cabin #_____

Camper's Name _____ Date of Birth _____ PIN _____

Address _____ Weight _____ Height _____

Health Insurance: YES___NO___ Insurance Carrier _____ Policy# _____

Physician's Name _____ Phone# _____ Dentist's Name _____ Phone# _____

In Case of Emergency, the Camp will call these numbers in the order listed:

Mother's Name _____ Home Phone _____ Cell _____

Father's Name _____ Home Phone _____ Cell _____

Other _____ Home/Cell _____ Relation To Camper _____

Other _____ Home/Cell _____ Relation To Camper _____

Medical History: (Please list all Medications taken at home or during the school year)

Allergies: YES___ List _____ NO___

_____ Medication _____

Asthma: YES___ Explain _____ NO___

_____ Medication _____

Autism: YES___ Explain _____ NO___

_____ Medication _____

ADD or ADHD: YES___ Explain _____ NO___

_____ Medication _____

Cardiac Disorders: YES___ Explain _____ NO___

_____ Medication _____

Diabetes: YES___ Explain _____ NO___

_____ Medication _____

Recent Surgery: YES___ Explain _____ NO___

_____ Date _____ Medication _____ NO___

Seizure Disorders: YES___ Explain _____ NO___

_____ Medication _____

_____ Medication _____

_____ Medication _____

Please list any medical condition or concern not listed above that we should be made aware of:_____

Secondary Camper Accident Insurance is provided. Coverage is for injury during the hours and days when Camp is in session and while attending or participating in Camp sponsored and supervised activities on or off Camp premises. Benefits are the maximum amount payable for covered expenses not recoverable from another plan providing benefits.

If I can not be reached, I give permission for emergency medical treatment, emergency transportation, hospitalization, anesthesia, x-rays or injection, and will be responsible for the bills of same. This authorization does not include major surgery, unless life-threatening, and only then when the medical opinion of two(2) licensed physicians or dentists concur in that treatment. I give my permission for the Camp Nurse to administer approved medications to my child(ren).

Both Parents or Custodial Parent Must Sign Below

Father's Name _____ Father's Signature _____ Date _____

Please Print

Mother's Name _____ Mother's Signature _____ Date _____

Please Print

American Heritage Summer Day Camp
Physician's Authorization for Medication Treatment

By **Law**, we are unable to administer **ANY** medicines or over-the-counter remedies without the authority of a physician. If your child needs to receive his/her prescription medicine during camp hours, they must arrive in a pharmacist's container, where the label clearly states the camper's name, the name of the medicine, the dosage, and the frequency of the dose. The Camp will provide name-brand, over-the-counter comfort remedies for the camper if this form is completed and signed by your child's physician.

Without this *Physician's Authorization Form*
The Camp can not administer, store, or even supervise your child's medical needs

Camper's Name _____

Last

First

List any allergy and diagnosis, or emergency precautions that The Camp should anticipate for this camper, i.e.: allergy triggers, diabetic reactions, etc. List all medications that are currently prescribed for this child. Include inhalers, Epipens, etc.

- | | Diagnosis | Medication, Dosage, Time, & Direction for Administering |
|----|--------------------------------------------|--------------------------------------------------------------------|
| 1. | _____ | _____ |
| | Side Effects & Specific Instructions _____ | _____ |
| 2. | _____ | _____ |
| | Side Effects & Specific Instructions _____ | _____ |
| 3. | _____ | _____ |
| | Side Effects & Specific Instructions _____ | _____ |

Medications available in The Camp's Clinic are administered by Registered Nurses

Does The Camp Nurse have your permission to administer the medications listed above and below? YES___ NO___

There are no extraordinary emergency medical services available at camp

Since only CPR and general first aid are available until emergency help arrives (911), is this adequate for this camper's above stated medical diagnosis? YES___ NO___

Medication	Route	Instruction	Can Nurse Administer
Bacitracin Ointment	topical	Abrasions/Minor Cuts	YES___ NO___
Benadryl Gel	topical	Itching/Insect Bites	YES___ NO___
Benadryl Elixir	p.o.	Anaphylactic Reaction Only	YES___ NO___
Cough Drops	p.o.	Cough	YES___ NO___
Hydrocortisone Cream 1%	topical	Contact Dermatitis	YES___ NO___
Hydrogen Peroxide	topical	Antiseptic Care	YES___ NO___
Ibuprofen	p.o.	Muscular-Skeletal Pain	YES___ NO___
Pepto-Bismol/Tums	p.o.	Upset Stomach	YES___ NO___
Robitussin Elixir	p.o.	Cough/Upper Respiratory Congestion	YES___ NO___
Throat Lozenges	p.o.	Sore Throat	YES___ NO___
Tylenol	p.o.	Aches/Pain/Fever	YES___ NO___

All of the above are administered per Manufacturer's Label Instruction by age and weight.

Mother's Signature _____ Date _____

Father's Signature _____ Date _____

Physician's Signature _____ Date _____

Physician's Stamp