AMERICAN HERITAGE SUMMER DAY CAMP

HEALTH SERVICES FORM / EMERGENCY CONSENT

PERSONAL AND CONFIDENTIAL

In order for our staff to properly care for your child, we ask that this form be completed on both sides and returned no later than: **May 1, 2014**

◆NOTE – Without signature – Off-Campus activities will be restricted ◆

Day Camp Only _____
Summer School / Camp Combo_____
Cabin #_____

Specialty Camps
Science Adventure___Theatre___ Soccer____ Tennis____
Young Artist_____ Robotics____Video Production ____

Session I (Wk-1 ____ Wk-2 ____ Wk-3 ___)

Session II (Wk-4 ____Wk-5 ____ Wk-6 ____)

Session III (Wk-7 ____ Wk-8 ____ Wk-9 ___)

Session I (Wk-1 ____ Wk-2 ____ Wk-3 ___)

Session II (Wk-4 ____Wk-5 ____ Wk-6 ____)

Session III (Wk-7 ____ Wk-8 ____ Wk-9 ___)

Camper Name_____D.O.B._____PIN_____
Last *First*

Address_____ Weight_____ Height_____
Street *City* *ST* *Zip Code*

In case of emergency, the staff will call these numbers in the order listed:

Mother's Name_____Home Phone_____Cell_____
Father's Name_____ Home Phone_____Cell_____
Other_____Home/Cell_____Relationship_____
Other_____Home/Cell_____Relationship_____
Health Insurance: YES___NO___ Insurance Carrier_____Policy#_____

Physician's Name_____Phone#_____Dentist's Name_____Phone#_____

The health services at American Heritage Summer Day Camp are to provide immediate first aid, administer medication and provide short-term care to campers until a parent or designated Emergency Contact can pick up the camper. A diagnosis cannot be made, nor are there facilities for extended periods of bed rest. We ask your cooperation in keeping sick children at home to prevent the spread of contagious illness.

Does your child have any restrictions on his/her activities? Yes _____ No _____
Does your child have any health needs, which require nursing care during camp hours? Yes _____ No _____
If yes, please specify: _____
_____

The camp nurse has my permission to share my child's health information with his/her counselors: Yes _____ No _____

TO BE COMPLETED BY THE CAMPER'S PARENT/GUARDIAN

I grant the nurse, head of camp or his/her designee the permission to assist or perform the administration for each medication or treatment/procedure for my child during the camp day including when he/she is away from camp property for official camp events.

Note: * Prescription medications must be supplied in the original container. Ask the pharmacist to divide medication into **2 labeled containers**, one for home **AND** one for camp.
* Camp personnel may administer only prescription medications/treatments authorized by a physician.
* It is your responsibility to notify the camp when there is a change in medication/treatment regime.

I understand that (1) there is no liability on the part of the camp, its personnel, or agents, and hereby release and waive any claims or actions against such persons or entity as the result of the administration of this medication to my child when the person administering the medication acts as an ordinarily reasonably prudent person would have acted under the same or similar circumstances; (2) this medication must be brought to the camp only by a responsible adult; (3) this medication must be in its original labeled container; (4) this medication will be destroyed if it is not picked up within one week following the above stop date or one week after the close of the current camp session, or when prescription expires, whichever occurs first. I hereby authorize the exchange of medical information regarding my child's treatment plan between the physician and campus health personnel.

_____ _____ _____
Parent/**Guardian Name (Print)** **Signature of Parent/Guardian** **Date**

If you have any questions or concerns please contact the clinic at 954-472-0022, Ext. 3071

If I cannot be reached, I give American Heritage Summer Day Camp permission for emergency medical treatment, hospitalization, anesthesia, or necessary 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 clinic staff/designee to administer approved medications to my child(ren).

(Both Parents or Custodial Parent must sign below.)

X Mother/Custodian _____ _____
Signature **Date**

X Father/Custodian _____ _____
Signature **Date**

Information will be valid for one (1) year

AMERICAN HERITAGE SUMMER DAY CAMP

PERMISSION FOR OVER-THE-COUNTER MEDICATION

PERSONAL AND CONFIDENTIAL

By **Law**, we are unable to administer **ANY PRESCRIPTION MEDICATION** without the authority of a physician. If your child needs to receive his/her prescription medicine during camp hours, the medication must arrive in a pharmacist's container, with the label clearly stating the child's name, the name of the medicine, the dosage, the frequency of the dose & the completed Authorization for Medication form. The Clinic Nurses will provide name brand; over-the-counter comfort remedies for the child with this completed Authorization, **signed** by the parent/guardian of the camper.

CAMPER NAME: _____ **DOB:** _____

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*_____

Seizure Disorders: YES___ Explain_____ NO___
_____
*Medication*_____

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

DIAGNOSIS **ORDERS – *Issued by United States licensed Physician***

1. _____ _____
_____
Side Effects & Specific Instructions _____
_____

2. _____ _____
_____
Side Effects & Specific Instructions _____
_____

◆Please **CROSS OFF MEDICATIONS** the student **MAY NOT** have, and enter any additional medications needed.

MEDICATION	DOSAGE	Route & frequency	INDICATIONS FOR USE
Acetaminophen (Tylenol)	po	per bottle instructions	headache or fever
Bacitracin Antibiotic Ointment	Topical	per package instructions	cuts and abrasions
Benadryl Elixir	po	per bottle instructions	allergic reactions
Benadryl Gel	Topical	per bottle instructions	itching or bug bites
Ibuprofen (Advil/Motrin)	po	per bottle instructions	headache, general pain

Other: _____

_____ _____ _____
PARENT/GUARDIAN NAME PRINTED **PARENT/GUARDIAN SIGNATURE** **DATE**

◆PLEASE COMPLETE REQUIRED AUTHORIZATION FOR MEDICATION FORM FOR ALL PRESCRIPTION MEDICATION◆