Campers Health Certification

***** Please complete all sections of this form and submit to the main office by June 1st *****

Information provided on this form will assist the health office staff in providing safe and appropriate care.

Part 1

Summer 20_____

Contact Information:

Camper Name: _____Birthdate: _____ Sex: ____ Age: ___

Mark Weeks **NOT** Enrolled: 1 2 3 4 5 6 7 8

Please list the persons you would like called in descending order:

1st Parent/Guardian: _____ Phone #: _____

2nd Parent/Guardian: _____ Phone #: _____

**If the above contacts are unavailable, please notify:

Name: _____ Relation: _____ Phone #: _____

Part 2

Health History:

- Chronic/recurring medical condition: NO YES _____
- Dietary restrictions/food allergies: NO YES _____
- Drug allergies: NO YES _____
- Environmental, insect, or other allergies: NO YES _____
- Operations OR serous injuries within the last two years: NO YES _____
- Any RESTRICTIONS to your child's camp activities: NO YES _____

NO YES, complete **Activity Restriction Form**

- List current medications:

_____

_____

_____

Part 3

Prescription and Over-the-Counter (OTC) Medications:

Our health office is staffed by registered nurses and certified first aid providers. Please be advised that the health office staff is not authorized to diagnose medical conditions or prescribe medication.

- If your child requires prescription medication during the camp day, the medication **must** be received in its original pharmacy container and properly labeled with the child's name, date of birth, and expiration date. A meication order from the prescribing provider must also be provided. **If your child has an allergy that requires an epi pen, please see part 4.**

- In the event your child should require over-the-counter medication during the camp day, written permission from a parent is required. Please note that prior to giving any oral medication, every attempt will be made to contact a parent or guardian. If unsuccessful in contacting a parent/guardian, the medication will be administered if deemed medically necessary by the health office staff. Dosages will be given according to the age/weight recommendations per the product label. The parent/guardian will be notified in writing.

- If your child is permitted to have OTC medication from the health office, please initial below:

_____ **Ibuprofen** (Advil/Motrin) for pain, fever, or inflammation

_____ **Acetaminophen** for pain, headache, fever

_____ **Calamine or BENADRYL** spray (itching, bug bites)

_____ **Benadryl Elixir** (allergic reaction to bite/sting)

_____ **Aloe Lotion** (for sunburn)

_____ **Antibiotic ointment (**minor wounds as needed)

_____ **TUMS** (upset stomach as needed)

Part 4

- ☐ Please check box if your child requires an **EPI-PEN** or **AUVI-Q** be kept at the health office.
- ☐ Please check box indicating that you have reviewed and completed the TSFDC Food List Form if applicable.
- ☐ Please check box indicating that you have submitted your child's Allergy Action Plan.

Signature

_____

(Parent or Legal Guardian Signature)

_____

(Date)