MEDICAL INFORMATION FOR CAMP NURSE

Youth Name:_________________________M( ) F( ) Birthdate: ___________ Age:__________
Address/City/Zip____
Parent/Legal Guardian _____________________ Phone:_______________ Cell: ____________
Emergency contact: ________________________ Relationship:____________ Phone: _______
List any present illnesses or physical restrictions:_______________________________________
____
List any health conditions: ____
List any allergies to food or medications:____
Date of last tetanus shot:________________________
Name of insurance company:_____________________________Policy Number: ____________

List any medications required to be given by the camp nurse:
1.________________________2.______________________3.___________________

4.________________________5.______________________6.___________________

If youth takes medications for sleep please keep in mind that the camp schedule can be very hard to keep up with if they are required to take these medications every night. Consider contacting youth's family doctor to request a **written** order that these medications may be given as needed instead of every night during camp, it must be in writing.

Parent and youth must meet with camp nurse upon arrival **IF** any medication is required.
If youth is on prescription medication, youth **MUST BE MATURE AND RESPONSIBLE FOR COMING TO THE CLINIC FOR REGULARLY SCHEDULED DOSES AS ORDERED BY PHYSICIAN.** Each medication **must** be in original labeled containers with name of youth and medication, dose, and times, and doctor's name. **If dose has been changed from label, youth must have statement from doctor.** The nurse is required to keep **ALL** medications secured. Youth may **NOT** keep any medications, even over the counter medications with them in the dorms.

PARENT MEDICAL AUTHORIZATION

I hereby authorize the Camp Sychar nurse or designated youth counselor to give over the counter medication (may be generic) to my child for minor illnesses as necessary, I have checked the medications below which my child (full name)_____________________**MAY** receive as needed:

Tylenol( ) Motrin( ) Tums( ) Sudafed( ) Cough drops( ) Benadryl( ) Pepto Bismol( )
Caladryl( ) Neosporin or Bactine for cuts( ) Imodium for diarrhea( ) Hydrocortisone cream( )
Aloe for burns( ) Colace for constipation( ) Robitussin DM for cough/congestion( )

I understand that in the event medical intervention is needed, every attempt will be made to contact me. If I cannot be reached in an emergency, I hereby authorize emergency medical treatment, injection, anesthesia, surgery, or dental care to be given to my son/daughter, as considered advisable or necessary in the judgment of an emergency medical professional or physician.
I understand that my insurance coverage for my child will be used as primary coverage in the event medical intervention is needed. Coverage by Camp Sychar through it's accident policy will be used as secondary coverage.

PARENT/LEGAL GUARDIAN: _____________________________ DATE:___________