Health Certification for Campers

Summer 20____

Please return ASAP, but no later then June 1st

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

Part 1

Contact Information:

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

Weeks Attending: 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 #: _____

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, complete **Activity Restriction Form**
- List current medications: _____

_____

_____

Part 2

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 medication under order from the child's physical must be provided along with any addition action plans or instructions.

☐ 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)

Bee/Insect Stings:

Our protocol is to remove the stinger when possible, apply supportive measures including Sting Relief/applying ice to site of sting, and then observe.

Please indicate below if there is a history of reaction known:

	No history - never been stung
	Has been stung. No significant reaction
	Family history of severe allergic reaction to bee stings

☐ Please check box if you will be sending in either an **EPI-PEN** or **AUVI-Q** into camp for the Health Office to hold for your child.

*Specify Allergy (*i.e. peanut, tree nut, bee sting _____

☐ I have completed and turned in **TSFDC Food List Form**

☐ I have completed and turned in the **Medication Policy and Order Form**.

☐ I have included the **action plan** prescribed by the physician.

☐ **Please check box if there is any addition information that the Health office should know concerning your child's care. Please attach an additional sheet of paper if needed.**

_____

(Parent or Legal Guardian Signature)

_____

(Date)