

Twin Spring Farm Day Camp

Camper Health Certification

Summer 20_____

Please return ASAP, but no later than 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 _____ Daytime contact number _____

2nd: parent/guardian _____ Daytime contact number _____

If above contacts are unavailable, please notify:

Name and relationship _____

Daytime contact number _____

Health History

Chronic/ recurring medical condition NO YES _____

Dietary restrictions/ food allergies NO YES _____

Drug allergies NO YES _____

Environmental, insect, other allergies NO YES _____

Operations OR serious injuries within the last two years NO YES _____

List current medications _____

Are there any RESTRICTIONS to your child's camp activities NO YES, Please complete **Activity Restriction Form**

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 Order Form' from the child's physician must be provided including the Action Plan (if appropriate) and directions to administer.
- 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 such as Sting Relief/applying ice to the site of sting, and then observe.

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

No history- never been sting

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 (ie peanut, tree nut, bee sting)

I have completed and turned in TSFDC FOOD list Form

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



Parent or legal guardian signature

Date