CHAMBERS CAMP & PENN YORK DISTRICT – HEALTH & MEDICATION FORM

Section A must be filled out by parent/guardian and section B must be filled out be the healthcare provider for the minor.

A. Name: _____ Sex: M / F Birth Date: _____ Age: _____

Address: _____ City: _____ State: _____Zip: _____

Health Ins. Co. _____ Member/ID No. _____ Group No. _____

Parent/Guardian:_____HomePhone:_____CellPhone_____

Emergency Contact (Not listed above): _____ Telephone: _____

Vaccinations: Please attach a copy of your child's most recent vaccination list WITH dates. OR: If your child is not vaccinated, please attach a copy of your school exemption letter.

***Vaccination List attached_____ Exemption letter attached_____ (Please check one)**

Medications: Please fill out the attached form for all of your child's prescribed medications. *All campers Must fill out form* *All medications must be in the original containers with labels!!

***Medication List attached_____**

Allergies: Is your child allergic to any Medications? No: _____ Yes: (please list) _____

Is your child allergic to any Food? No: _____ Yes: (please list) _____

Does your child have any Other allergies? No: _____ Yes: (please list) _____

Other: 1. Has your child been exposed to any communicable diseases recently?

No: _____ Yes: (please explain) _____

2. Does the camper have any limitations or restrictions that would prevent them from participating in any physical activities?

No: _____ Yes: (please explain) _____

3. Does this camper struggle with: Bedwetting: No: ____ Yes: ____
Sleepwalking: No: ____ Yes: ____
Night Terrors: No: ____ Yes: ____

4. Are there any other Medical or Additional information our staff should be aware of concerning this camper? (Ex: Dietary, Disability, Major operations, Special precautions, Seizures, Emotional concerns, etc.)

No: _____ Yes: (please explain) _____

Permission for my child to use insect repellent & sunscreen:

Insect Repellent & Sunscreen ***Brought to camp by camper, non-aerosol only****	Per Label instruction	My son/daughter may apply or, if requested to a leader, may have applied, insect repellent and sunscreen that he/she has brought to camp.	Yes No	Parent Signature required here

I hereby grant permission for my child/self to attend/work at Chambers Wesleyan Camp. In the event of an emergency, I hereby give my permission for self/him/her to receive any such medical treatment as is necessary for serious illness or injury, as administered by the camp health staff, and/or hospital.

_____ _____

Signature of Parent/Legal Guardian, or Self if over 18 **Date**

***A health form without a signature will not be accepted.**

TURN PAGE OVER: MEDICATION PORTION TO BE FILLED OUT BY HEALTH CARE PROFESSIONALS

B. **Child's Doctor must fill out this section:**

Oral Agents	Dosage	Indication	Approved	Comments
Benadryl		Allergic Reaction/hay fever every six hours as needed for 24 hours	Yes No	
Ibuprofen		Headache, pain control	Yes No	
Imodium		As needed for watery stool	Yes No	
Pepto Bismol		Upset stomach	Yes No	
Robitussin		Colds, every six hours as needed	Yes No	
Tylenol		Fever, headache, pain control, toothache every 4 hours as needed	Yes No	
Topical Agents				
Triple Antibiotic Ointment		Wound care	Yes No	
Desenex Powder		Athletes foot	Yes No	
Gold Bond Powder		Jock itch	Yes No	

Camper's Current Prescription and Over-the-Counter Medications ***Medications include, but are not limited to: prescription medications, over the counter medications, ointments, prescription face wash, homeopathic remedies, and vitamins. All medications, properly labeled, in the <u>ORIGINAL CONTAINER</u>, and with a valid expiration date are required to be turned into the camp medical staff upon registration.**

Drug Name	Dosage	Schedule AM/PM/Meals/bed/as needed	Comments (With food etc.)

Is your camper aware of what medications he/or she will be taking while at camp? ____Yes _____No

This form Must be sign by the parent/guardian as well as the Camper's Health Care Provider in order for the above over-the-counter medications* to be received, as per New York State Law.

Health Care Provider_____ Phone: _____

Address/City/State/Zip_____ License #_____

Signature: _____ Date: _____

Parent/Guardian Approval: I request that my son/daughter receive the above over-the counter medications as indicated by my child's Health Care Provider (required for under the age of 18) as needed.

Parent/Guardian_____ Phone: _____