



Camp Hemlock

* Staff Use only Cabin # _____

Camper Medical and Emergency Information

Name: _____ Age: _____
Date of Birth: _____ Weight: _____
Address: _____

Primary Contact: _____ Secondary Contact: _____
Relation: _____ Relation: _____
Home Phone: _____ Home Phone: _____
Cell Phone: _____ Cell Phone: _____
Work Phone: _____ Work Phone: _____

Pediatrician's name and phone number: _____
Date of last tetanus booster: _____
Family Insurance Company: _____
Insurance Address: _____
Policy No: _____
Name of Policy Holder: _____
Policy Holder Date of Birth: _____
Policy Holder Address: _____
Policy Holder Employer: _____

Allergies (please note severity and last incident's treatment): _____

Health History Check any of the following health situations your child may have:
Asthma ___ ADHD ___ Anxiety ___ Diabetes ___ Bed Wetting ___ Ear Infection ___
Fainting ___ Seizures ___ Heart Condition ___ Kidney Condition ___ Sleep Walking ___
Psychiatric or Emotional Disorders ___ Bleeding/clotting disorders ___ Hypertension ___
Other: _____

* If your child has any handicaps that may hinder participation in the full camp program, please contact us so that we may know how to best help your child have a great time at camp.

Please bring a photo-copy of both sides of your child's health insurance card

The health history above is correct as far as I know. In case of emergency, I grant camp staff permission to administer first aid and seek medical attention as needed. I will assume obligation for the necessary expenses through my personal insurance policy. It is my understanding that primary insurance coverage is provided through my family medical policy and that the camp insurance acts as secondary coverage. It will be necessary to pay care-givers at the time of service pending insurance claim processing. In case of emergency, I give my permission to the physician selected by the Camp Director or Designee to secure proper treatment for my child. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I hereby give permission to the physician selected by the camp to secure and administer treatment for the person named above. I will accept full responsibility for my child's physical condition with the following limitations (If none, write "none"): _____

Parent or Guardian Signature: _____ Date: _____



Camp Hemlock

* Staff Use only Cabin # _____

Camper Medication Information

Camper's Name: _____

Medication Allergies/Sensitivities: _____

For each allergy, note the severity and last incident's treatment: _____

1. All prescription medications must be brought to camp in their original containers with doctor's instructions. DO NOT pre-dispense, place in a daily pill holder, wrap in outer materials, or ask us to dispense by other than doctor's orders. Do not bring expired medications. Medications not in original containers will not be held or dispensed at camp.
2. Please indicate if medicine is taken daily or as needed.
3. You must be specific with any variations or conditions associated with "as needed".
4. If your son/daughter will need to bring an inhaler, Epi-Pen, or other emergency medication to camp, please speak to the camp nurse or designee at check-in.

List all medications with appropriate directions that your child receives on a **routine/regular basis** including all prescription, over-the-counter, and homeopathic medications (all supplied by parent):

Medication	Dosage/Directions
1.	
2.	
3.	

List any as-needed prescriptions, over-the-counter, or homeopathic medications (supplied by parent) with appropriate directions. (Example: metered dose inhalers and Epi Pens)

Medication	Dosage/Directions/Conditions for Use
1.	
2.	
3.	

Please check any medications you wish made available to your child from the health center and cross out those the camper should **NOT** be given:

<input type="checkbox"/> Acetaminophen (Tylenol)	<input type="checkbox"/> Ibuprofen (Advil, Motrin)	<input type="checkbox"/> Diphenhydramine (Benadryl)
<input type="checkbox"/> Hydrocortisone cream	<input type="checkbox"/> Antibiotic cream (Bacitracin)	<input type="checkbox"/> Neosporin
<input type="checkbox"/> Tinactin cream or powder	<input type="checkbox"/> Throat Lozenges	<input type="checkbox"/> Robitussin Cough Syrup
<input type="checkbox"/> Pepto-Bismol	<input type="checkbox"/> Tecnu lotion	<input type="checkbox"/> NyQuil
<input type="checkbox"/> Cepacol Sore Throat Spray	<input type="checkbox"/> Lotrimin Cream	<input type="checkbox"/> DayQuil
<input type="checkbox"/> Calamine/Caladryl Lotion	<input type="checkbox"/> Mucinex	<input type="checkbox"/> Tums

I hereby give permission for my child, _____, to receive the named prescriptions, over-the-counter medications (or generic equivalent), and homeopathic medications checked above on this form. I understand that these medications will be administered by the camp nurse, Camp Director, or designee.

I do not want any medication give to my child at camp. ____

If your child has a communicable disease, please do not bring him or her to camp. I understand that if my child has a fever, he or she may need to be picked up from camp.

Parent or Guardian Signature: _____ Date: _____