Hemlock Wilderness Brigade Camp & Camp Wildflowers

** Staff Use Only* **Cabin #:**_____*

MEDICAL AND EMERGENCY INFORMATION *(Rev. 2015)*

Camper's Name: _____ Date of Birth: _____

This form and the "CAMPER MEDICATION INFORMATION" form MUST be submitted to the Health Station upon arrival at Camp in order for the camper to remain at camp without a parent. These forms are required for the administration of medication. Each and every medication must be supplied in an original pharmacy bottle or manufacturer's package and labeled with your child's name.

Check allergic reactions to: Bee Stings_____ Hay Fever_____ Poison Ivy/Sumac/Oak_____

List any food allergies: _____

For each allergic reaction, note severity and last incident's treatment: _____

_____

Check any of the following health problems your child may have: Asthma____ ADHD____
Anxiety____ Diabetes____ Bed Wetting____ Ear Infection____ Fainting___ Seizures____
Heart Condition____ Kidney Condition____ Sleep Walking____ Psychiatric or Emotional Disorders___
Other: _____

Has your child had any serious operations or illnesses? Yes/No. If Yes, Explain: _____

_____

* 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. *

Pediatrician's name and phone number: _____

Date of last tetanus booster: _____

Family Insurance Company: _____

Address: _____

Policy No.: _____

Name and Date of Birth of Policy Holder: _____

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

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 will accept full responsibility for my child's physical condition with the following limitations (If none, write "none"):

_____

Parent or Guardian Signature:_____**Date:** _____

Primary Contact: _____

Relation: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Secondary Contact: _____

Relation: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Hemlock Wilderness Brigade Camp & Camp Wildflowers

* *Staff Use Only* **Cabin #:**_____*

CAMPER MEDICATION INFORMATION

Camper's Name: _____

Medication Allergies/Sensitivities: _____

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

1. 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.	

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

Medication	**Dosage/Directions**
1.	
2.	
3.	

3. Please check any over-the-counter medications you wish to be made available to your child:

For Headache /Fever /Earache /Muscle Aches

☐ Acetaminophen (Tylenol) – 325mg.
Two tablets every 4 hours by mouth

☐ Ibuprofen (Motrin) - 200 mg.
One tablet every 4 hours by mouth

☐ Children's Tylenol - *Dosage according to age/weight guidelines on package*

For Mild Allergic Reactions /Rashes /Insect Bites

☐ Diphenhydramine (Benadryl) - 25 mg.
Tablet or liquid, by mouth, one dose every 6 hours

☐ Hydrocortisone cream - 1.0%
Topically to skin twice daily

For Athlete's Foot /Jock Itch

☐ Lotrimin Cream
Topically to skin twice daily

☐ Tinactin spray powder
Topically to skin twice daily

For Coughs /Sore Throat

☐ Throat Lozenges

☐ Cough Syrup (Robitussin) - *Dosage according to age/weight guidelines on package*

For Gastrointestinal Upset

☐ Pepto-Bismol: *Oral dosage according to labeled guidelines.*

☐ Tums: *2 to 4 tablets as needed not to exceed 15 tablets during a 24 hour period.*

For Minor Wounds

☐ Bacitracin ointment: *Topically*

For Contact Dermatitis (Poison Ivy /Poison Sumac /Poison Oak)

☐ Tecnu lotion: *Topically*

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 Director or designee.
I do not want any medication given 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: _____