



# 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: \_\_\_\_\_

**Date of last tetanus booster:** \_\_\_\_\_

\* 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. \*

**Family Insurance Company:** \_\_\_\_\_

Address: \_\_\_\_\_

Policy No.: \_\_\_\_\_

### 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: \_\_\_\_\_

Secondary Contact: \_\_\_\_\_

Relation: \_\_\_\_\_

Relation: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_



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## 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:

<p><b>For Headache /Fever /Earache /Muscle Aches</b></p> <p><input type="checkbox"/> Acetaminophen (Tylenol) – 325mg. <i>Two tablets every 4 hours by mouth</i></p> <p><input type="checkbox"/> Ibuprofen (Motrin) - 200 mg. <i>One tablet every 4 hours by mouth</i></p> <p><input type="checkbox"/> Children's Tylenol - <i>Dosage according to age/weight guidelines on package</i></p>	<p><b>For Mild Allergic Reactions /Rashes /Insect Bites</b></p> <p><input type="checkbox"/> Diphenhydramine (Benadryl) - 25 mg. <i>Tablet or liquid, by mouth, one dose every 6 hours</i></p> <p><input type="checkbox"/> Hydrocortisone cream - 1.0% <i>Topically to skin twice daily</i></p>	<p><b>For Athlete's Foot /Jock Itch</b></p> <p><input type="checkbox"/> Lotrimin Cream <i>Topically to skin twice daily</i></p> <p><input type="checkbox"/> Tinactin spray powder <i>Topically to skin twice daily</i></p>
<p><b>For Coughs /Sore Throat</b></p> <p><input type="checkbox"/> Throat Lozenges</p> <p><input type="checkbox"/> Cough Syrup (Robitussin) - <i>Dosage according to age/weight guidelines on package</i></p>	<p><b>For Gastrointestinal Upset</b></p> <p><input type="checkbox"/> Pepto-Bismol: <i>Oral dosage according to labeled guidelines.</i></p> <p><input type="checkbox"/> Tums: <i>2 to 4 tablets as needed not to exceed 15 tablets during a 24 hour period.</i></p>	<p><b>For Minor Wounds</b></p> <p><input type="checkbox"/> Bacitracin ointment: <i>Topically</i></p> <p><b>For Contact Dermatitis (Poison Ivy /Poison Sumac /Poison Oak)</b></p> <p><input type="checkbox"/> Tecnu lotion: <i>Topically</i></p>

- 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: \_\_\_\_\_