

Hemlock Wilderness Brigade Camp
PHYSICIAN ORDER AND CONSENT FOR ADMINISTRATION OF MEDICATIONS (Rev. March 2003)
Required at Check-In With Physician's Signature

Camper's name: _____ Date of Birth: _____

Medication Allergies/Sensitivities: _____

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:

<u>For Headache/Fever* /Earache/Muscle Aches</u> <input type="checkbox"/> Acetaminophen (Tylenol) – 325mg. <i>Two tablets every 4 hours by mouth</i> <input type="checkbox"/> Ibuprofen (Motrin) – 200 mg. <i>One tablet every 4 hours by mouth</i> <input type="checkbox"/> Children's Tylenol— <i>Dosage according to age/weight guidelines on package</i>	<u>For Mild Allergic Reactions/Rashes/Insect Bites</u> <input type="checkbox"/> Diphenhydramine (Benadryl) – 25mg <i>Tablet or liquid, by mouth, one tablet or dose every 6 hours</i> <input type="checkbox"/> Hydrocortisone cream --1.0% <i>Topically to skin twice daily</i>	<u>For Athlete's Foot/Jock Itch</u> <input type="checkbox"/> Lotrimin Cream <i>Topically to skin twice daily</i> <input type="checkbox"/> Tinactin spray powder <i>Topically to skin twice daily</i>
<u>For Coughs/Sore Throat</u> <input type="checkbox"/> Throat Lozenges <input type="checkbox"/> Cough Syrup (Robitussin) <i>Dosage according to age/weight guidelines on package</i>	<u>For Gastrointestinal Upset</u> <input type="checkbox"/> Pepto-Bismol: <i>Oral dosage according to labeled guidelines</i> <input type="checkbox"/> Maalox <i>Two tablets every 2 hours by mouth</i>	<u>For Minor Wounds</u> <input type="checkbox"/> Bacitracin ointment: <i>Topically</i> <u>For Contact Dermatitis (Poison Ivy/Oak)</u> <input type="checkbox"/> Calamine lotion: <i>Topically</i>

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.

Parent/Guardian Signature: _____ Date: _____

Home Phone: _____ Work/Emergency/Beeper: _____

Physician (Printed): _____ Office Phone: _____

Physician Signature: _____ Date: _____

* I understand that if my child has a fever, he or she may need to be picked up from camp.

Hemlock Wilderness Brigade Camp
General Delivery Post Office
Wardensville, WV 26851
304-874-3586

MEDICAL AND EMERGENCY INFORMATION (Rev. March 2003)

CAMPER NAME: _____ CAMPER SSN#: _____
LEADER: _____ CABIN/TENT#: _____

This form, and the "PHYSICIAN ORDER AND CONSENT FOR ADMINISTRATION OF MEDICATION" form MUST be submitted to the Health Station upon arrival at Camp in order for the camper to be permitted to remain at camp without a parent. These forms are also required for the administration of medication, even when a parent is present. 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: _____

Check any of the following health problems you child may have:
Asthma _____ ADHD _____ Anxiety _____ Bed Wetting _____ Diabetes _____ Ear Infection _____
Fainting _____ Heart Condition _____ Kidney Condition _____ Seizures _____
Psychiatric or Emotional Disorders _____ Sleep Walking _____ Other _____

Does your child have any handicaps that may hinder participation in the full camp program? Yes/No
If Yes, Explain: _____

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

Date of last tetanus booster: _____

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"):

Family Insurance Company: _____
Address: _____
Policy No.: _____

Parent or Guardian Signature: _____ SSN# _____
Home Phone: _____ Work Phone: _____

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

If your child has a communicable disease, please do not bring him or her to camp.