Camp Hemlock

* Staff Use only Cabin # ______

Camper Medical and Emergency Information

Name: ___________________________Age:___________________
Date of Birth: _____________________Weight: _______________
Address: ____

Primary Contact: __________________
Relation: _________________________
Home Phone: _____________________
Cell Phone: _______________________
Work Phone: _____________________

Secondary Contact: ________________________
Relation: __________________________________
Home Phone: ______________________________
Cell 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: _________________

2828 Trout Run Road, Wardensville, WV 26851
Camping Season: 304-874-3586 www.camphemlock.org

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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 <u>NOT</u> be given:

Acetaminophen (Tylenol)	Ibuprofen (Advil, Motrin)	Diphenhydramine (Benadryl)
Hydrocortisone cream	Antibiotic cream (Bacitracin)	Neosporin
Tinactin cream or powder	Throat Lozenges	Robitussin Cough Syrup
Pepto-Bismol	Tecnu lotion	NyQuil
Cepacol Sore Throat Spray	Lotrimin Cream	DayQuil
Calamine/Caladryl Lotion	Mucinex	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 <u>do not</u> 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: ________________

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