



Day Camp Health History & OTC Medications

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Adult Camper

Name _____ Date of Birth _____ Sex _____ Age _____

Address _____ City _____ State _____ ZIP _____

Parent/Guardian Name(s) _____

Primary Phone (_____) _____ Secondary Phone (_____) _____

Family Medical/Hospital Insurance Carrier _____ Policy or Group # _____

Emergency Contact #1: Name _____ Relationship _____

Daytime Phone (_____) _____ Evening Phone (_____) _____

Emergency Contact #2: Name _____ Relationship _____

Daytime Phone (_____) _____ Evening Phone (_____) _____

Health History Record (Check all that apply)

Chronic or recurring illnesses:

- Heart Defect / Disease _____
- Seizures _____
- Bleeding / Clotting _____
- Asthma _____
- Diabetes _____
- Other (specify) _____

Any restrictions concerning physical activities?

- No Yes. Please describe any conditions:

Allergies:

- Food, Nuts _____
- Insect Stings _____
- Medicine / Drugs _____
- Other (specify) _____

Special dietary restrictions? _____

Tetanus Date of last booster? (year) _____

Please list any medications taken on a daily basis, including over-the-counter medications: _____

Any other relevant health concerns _____

Camper Only - Over-the-Counter Medications

According to our *Day Camp Protocols and Health Care Procedures*, our health care staff can administer certain types of over-the-counter (OTC) medications. In order for your camper to be able to receive these, we need to have a parent/guardian signature.

Check box if camper MAY RECEIVE any of the following OTC medications:

- | | |
|--|---|
| <input type="checkbox"/> Acetaminophen (Tylenol or generic) | <input type="checkbox"/> OTC Antacid (Tums) |
| <input type="checkbox"/> Ibuprofen (Advil or generic) | <input type="checkbox"/> Calamine lotion |
| <input type="checkbox"/> Diphenhydramine (Benedryl or generic) | <input type="checkbox"/> Antibiotic Ointment |
| <input type="checkbox"/> Non-medicated cough drops | <input type="checkbox"/> Sunscreen (without PABA, minimum SPF 30) |
| <input type="checkbox"/> Insect repellent (may contain up to 15% DEET) | <input type="checkbox"/> Hydrocortisone |

Weight of child for dosage purposes: _____

(Unchecked boxes means camper MAY NOT receive that medication.)

<p>Camper I/we verify that this health history is complete and accurate. My child has permission to engage in all prescribed activities, except as noted by me. In case of illness or injury, I/we give permission for her/him to receive first aid and to receive emergency treatment from a licensed physician, emergency medical services or other health care professional. It is understood that all reasonable efforts will be made to contact the parent or guardian. I/we verify my child has my permission to receive the above-mentioned over-the-counter medications.</p> <p>Signature of Parent(s)/Guardian _____ Date _____</p> <p>Adult I verify that this health history is complete and accurate. I am able to engage in all prescribed activities, except as noted.</p> <p>Signature of Adult _____ Date _____</p>
