Year:

Office Use Only:

Group: _____

Reviewed: _____

Parental Authorization & Medical Form

Camper Information:

Last Name: _____ First: _____ Approx. Weight: _____

Date of Birth (m/d/yr): _____ Age: _____ Grade Entering in Fall: _____

Which Camp?: ☐ Big Oak (6-14) ☐ Little Buds (2-5 or just finished K) ☐ Expressions (6-18)

Do you need AM/PM extended care? ☐ Yes ☐ No Approx. Drop Off/Pick Up Time: _____

Parent/Guardian Information:

Primary Parent Name: _____

Cell Phone: _____ Email: _____

Secondary Parent Name: _____

Cell Phone: _____ Email: _____

EMERGENCY CONTACT OTHER THAN PARENT AUTHORIZED TO GIVE CONSENT:

Name: _____ Cell: _____ Relation: _____

OTHERS AUTHORIZED TO PICK UP MY CHILD FROM CAMP:

Name: _____ Cell: _____

Name: _____ Cell: _____

MEDICAL & HEALTH INFORMATION:

Does your child have Asthma, Food Allergies or EPI PEN: ☐ Yes ☐ No (If yes you MUST complete page 2)

General Medications: My child may receive (check all that apply):

- ☐ Tylenol
- ☐ Ibuprofen
- ☐ Benadryl
- ☐ Tums
- ☐ Pepto Bismol
- ☐ Call first

Medications to be Administered at Camp: list any medication to be given during camp hours and when. It must be provided in the original container with the child's name, dosage, and prescriber information.

Medication: _____ When: _____

Medication: _____ When: _____

Any additional information: _____

*I understand that medication that I provide to Camp Concepts may be dispensed by a staff member according to the instructions that I have outlined above if the nurse is not available. I also give permission for my child to receive necessary emergency medical treatment if needed. The form will be used to provide health history information to medical staff to begin treatment. I will be contacted as soon as possible to provide any additional information. I also give my consent for my child (BO or EX) to be transported in camp owned, leased or arranged transportation to off campus activities. *LITTLE BUDS DO NOT LEAVE CAMPUS*

PARENT NAME: _____ (*Typed name equivalent to a verified signature)*

Date: _____

Email to accounts@campconcepts.org or print and bring to camp

Page 2: Supplemental Camper Allergy and Medical Information

Camper Last Name: _____ First: _____ Approx. Weight: _____

Asthma:

Does your child have asthma? ☐ Yes ☐ No (*provide action plan)*

Is the inhaler needed at camp? ☐ Yes ☐ No

Where should the inhaler be kept? ☐ Nurse's office ☐ Counselor ☐ Camper

Is the inhaler ☐ rescue or ☐ preventative?

Please describe when your child should use the inhaler: _____

What can bring on an asthma attack? _____

Does your child recognize the need for their inhaler? ☐ Yes ☐ No

Any additional asthma information: _____

Allergies: Food, Medication, or Environmental

Specifically list any allergies and indicate if it is ingestion, contact, or both:

Typical symptoms of a reaction:

Is an epi-pen required? ☐ Yes ☐ No

For what allergy is the epi pen required? _____

(epi-pen will be kept in the office at camp and travel off-campus)

Has the epi-pen ever been administered? ☐ Yes ☐ No

Does your child need to sit at a food allergy table?: ☐ Yes ☐ No

Food must come from a peanut/nut free facility: ☐ Yes ☐ No

Does your child recognize reaction symptoms? ☐ Yes ☐ No