Matthew Salem Camp Health History and Care Services

This information is needed to ensure that your son or daughter will receive the best possible care in the event of accident, illness or emergency. **This form MUST be completed and signed by a parent or guardian and is valid for only one calendar year.** This information will be kept confidential and used only for the participant's welfare. PLEASE PRINT or TYPE!

Name: _____County:_____

Street Address: _____City/State/Zip_____

Date of Birth: _____/_____/_____ Circle: Male Female

Email Address _____

Home Phone Number: (_____) _____

In case of emergency, contact us in this order:

Name _____ Phone # : (_____)_____

Name _____ Phone #: (_____)_____

Name _____ Phone # : (_____)_____

Name _____ Phone #: (_____)_____

Physician's Name: _____ Telephone # :(____)_____

Dentist's Name : _____ Telephone # :(____)_____

Please list ALL medical diagnoses as they pertain to your camper:

_____

_____

_____

_____

_____

_____

_____

INSTRUCTIONS FOR MEDICATIONS: Prescription Drugs/Over-the-Counter Medications
Please complete the following information on all medications required by your child.
All prescription drugs needed must be given to the nurse/health care provider for storage and dispensing.

Please put all medications in a zip lock bag with your child's name on it.

CHECK IF PARTICIPANT IS SUBJECT TO:

	Athlete's Foot		Ear Infections		Home sickness
	Bed Wetting		Epileptic Seizures		Kidney trouble
	Bronchitis		Fainting		Sinusitis
	Constipation		Frequent Colds		Sleep Walking
	Convulsions		Frequent sore throat		Other
	Cramps		Headaches		Other
	Diarrhea		Heart Trouble		Other

The following is a list of items which the camp will have on hand during your child's stay at camp.
PLEASE CHECK EACH ITEM YOU GIVE PERMISSION FOR YOUR CHILD TO HAVE DURING CAMP IF NEEDED:

	Advil: 100 mg tablets		Cortisone Cream 1%		Tylenol: 80 mg per tablet
	Benadryl: 12.5 mg tablets		Triple Antibiotic Cream		Tums Regular Strength

A listing of each medication brought to camp (prescription or non-prescription-over-the-counter medication) must be provided. Please copy form if necessary

Medication Section

Name of Medication	Mg Provided In	Dosage Administered	Time(s) Administered	Precautions/Possible Reactions

CAMPER ALLERGIES (please be specific):
Foods _____

Serious ivy, oak or sumac poisoning: _____Bee or insect stings: _____

Allergy Medication: prescription or non-prescription drugs:
_____

Special Dietary Needs:
_____
_____
_____

PLEASE SPECIFY DETAILS OF ANY OTHER PREVIOUS MEDICAL CONDITIONS, ACCIDENTS OR INJURIES WITHIN THE LAST 5 YEARS (INCLUDING BREAKS, SPRAINS OR STRAINS)

_____

_____

SPECIFY ANY RESTRICTIONS IN ACTIVITIES: _____

_____

PARENT/GUARDIAN MEDICAL RELEASE

_____(Child's name) has my permission to participate in the Matthew Salem Camping Foundation program (with the exception of those listed above). I understand the participants will be supervised. I understand that the volunteers of the Matthew Salem Camping Foundation are not responsible in the event of accidental injury or illness, nor for the compounded injury or illness to the participant's present medical conditions listed above. We/I the undersigned, who are the parents/guardians of the above mentioned child, request that the health care service outlined above and prescribed by the above physician be provided to our child. We/I authorize the camp to appoint a qualified designated person(s) to perform the above prescribed treatment as directed by the physician. We/I agree to notify the camp personnel immediately if there is any change in either the child's treatment regimen or the authorizing physician.
I further understand that in case of serious injury or illness, I will be notified. If I cannot be contacted, I give my permission to transport or arrange for transportation to an appropriate medical facility and for the attending physician to hospitalize, secure proper treatment, and to order injections, anesthesia, or surgery for the participant named above.

Signature _____ Date _____