Part 1 - Parent Health Certification for Campers

Both Sides To be Completed by Parent.

Return ASAP, but please no later than April 15th.

NOTE Camp Policy:
Your child may not begin camp until this form is on file at Camp.

Information on this form is not part of the camper acceptance process, but is gathered to assist us in identifying appropriate care.

Name_____ Birthdate _____ Sex _____ Age _____

Camper Home Address_____

List the first person you'd like us to call!

First Contact _____ *parent/guardian* Daytime Phone(s)_____ 1 ☐ Cell ☐ Home ☐ Office 2 ☐ Cell ☐ Home ☐ Office 3 ☐ Cell ☐ Home ☐ Office

Second Contact _____ *parent/guardian* Daytime Phone(s)_____ 1 ☐ Cell ☐ Home ☐ Office 2 ☐ Cell ☐ Home ☐ Office 3 ☐ Cell ☐ Home ☐ Office

If above contacts unavailable, notify_____ *Name & Relationship* Daytime Phone(s) _____ 1 ☐ Cell ☐ Home ☐ Office 2 ☐ Cell ☐ Home ☐ Office 3 ☐ Cell ☐ Home ☐ Office

Does your child:	**YES**	**NO**	**IF YES, PLEASE EXPLAIN BELOW.**
Have any chronic or recurring medical condition?	☐	☐	_____
Have any dietary restrictions or food allergies?	☐	☐	_____
Have any drug allergies?	☐	☐	_____
Have any environmental, insect, or other allergies?	☐	☐	_____
List operations or serious injuries (dates).	☐	☐	_____
Has your child ever had a seizure?	☐	☐	_____
Are there any restrictions to your child's camp activities?	☐	☐	_____

List current medications (send with instructions) _____

Name of family physician _____ Phone _____

Name of dentist _____ Phone _____

Name of orthodontist _____ Phone _____

Do you carry medical/hospital insurance? ☐ Yes ☐ No Through employer (name) or personal _____

Carrier: _____ Policy Number: _____ Policyholder Name: _____

For Female: Has camper menstruated? _____ If not, has she been told about it? _____

If so, is menstrual history normal?_____ Special Consideration? _____

IMPORTANT - THIS BOX MUST BE COMPLETED*

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted. Authorization for Treatment: I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the nurse and/or physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. The completed forms may be photocopied.

I hereby authorize any physician, nurse or other health care provider, to communicate with the medical staff and director, of Sesame/Rockwood Camps, or his/her designee, about my child's medical condition, treatment and/or prognosis. I further authorize the camp medical staff to discuss medical conditions with the director, his/her designee, or the child's counselor when the medical staff, in its sole discretion, believes such communication to be in the best interest of my child. These authorizations are limited to this camp season.

Signature of parent or legal guardian_____ Date _____

**If for religious reasons you cannot sign this, camp should be contacted for a legal waiver which must be signed for camp attendance.*

Return completed form (both sides) to Sesame/Rockwood Camps • Box 385 • Blue Bell, PA 19422 • FAX: 610-279-4463

Part 2 - Parent Health Certification for Campers

Both Sides To be Completed by Parent. Return ASAP, but please no later than April 15th.

Child's Name _____ **Date of Birth**_____

OUR HEALTH CENTER IS STAFFED BY REGISTERED NURSES AND CERTIFIED FIRST AIDERS.
THE HEALTH CENTER PERSONNEL MAY NOT DIAGNOSE OR PRESCRIBE MEDICATION OR TREATMENT.

- **In order to relieve your child's distress when ill, the Camp Health Personnel needs your written permission to administer the following over-the counter medications. Medications will be administered only when deemed necessary by Camp Health Personnel, and only at recommended weight/age dosages as listed on the product label.**

- Please place your initials next to whichever over-the-counter medications you are authorizing. If you do not authorize medications supplied by camp, please initial the space provided for "NO" and indicate the substitute that you will send to camp for your child.

1. For Pain, Fever, Cramps, Headache - Choose only one.

_____ **NO PREFERENCE**. Camp has my permission to administer **EITHER Acetaminophen (Generic substitute for Tylenol®) OR Ibuprofen (Generic substitute for Advil®).**

_____ Camp has my permission to administer **ONLY Acetaminophen (Generic for Tylenol®).**

_____ Camp has my permission to administer **ONLY Ibuprofen (Generic for Advil®).**

_____ NO, I will send in _____.

Please indicate what your child prefers: ___ Liquid ___Chewable Tablets ___ Pill (swallow)

2. For Allergic Reaction to Insect Bite/Sting - Benadryl® or Generic Diphenhydramine

_____ YES, Camp has my permission to administer. _____ NO, I will send _____

3. To Relieve Itching (Poison Ivy/Insect Bite/Rash)-Anti-Itch Topical (Benadryl® spray/Caladryl® Lotion)

____ YES, Camp has my permission to administer. _____ NO, I will send _____

If you send in an alternate over-the-counter remedy or prescription medication, it must be kept at the Health Center. All medications sent from home must be in the **original pharmacy container**, and if prescription, **prescribed in the name of the child**.
ALL medications must be properly labeled with child's name, and accompanied by instructions, signed by parent/guardian, indicating dosage, and time(s) to be administered.

- **For bee/insect stings, our protocol is to remove the stinger when possible, apply ice at site of bite/sting, and observe child. Benadryl® will be administered if deemed necessary by Health Center Staff, or if there is a history of reaction as indicated below. For a severe reaction, an Epi-Pen® will be given when supplied by parent.**

☐ No History -- has never been stung. ☐ Has been stung - No Reaction

☐ Check here if anyone in your family has experienced a severe allergic reaction to bee/insect stings.

- **EPI-PEN® PLEASE COMPLETE THIS SECTION ONLY IF SENDING AN EPI-PEN® TO CAMP**

(NOTE: AT least two Epi-Pens® are required ... one will remain at the Health Center, and the other with the Trans Counselor)
If yes, please specify for what allergy: (ie., peanut, bee sting, food) _____

☐ *If there is any additional information that the Camp Health Center should know concerning your child, please check box at left and attach a separate sheet to this form. Thank you.*

Signature of parent or legal guardian_____ Date _____

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