



**ADDENDUM TO
CAMP HEALTH FORM**
to be completed by parent/guardian

| |
|------------------|
| Last name _____ |
| First name _____ |

Please be as complete & specific as possible concerning your child's health.

PRESCRIPTION MEDICATIONS

- List all prescription medications that you will be sending with your child.
- ALL medications must be prescribed for the child and sent in the ORIGINAL CONTAINER. Be sure that the label specifies the directions to be followed. ("AS DIRECTED" on the container is not sufficient. If necessary, have specific directions sent by the prescribing physician.)
- If the medication order has been changed in any way since it was originally prescribed, or if it is changed prior to camp, a note from your physician with the new directions will be required.

PRINT THE **NAMES ONLY** OF THE PRESCRIPTION MEDICATIONS:

| | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

"OVER-THE-COUNTER" MEDICATIONS

I give permission for my child, _____, to receive the following "over-the-counter" medications, or their generic equivalent, on an "as needed" basis. Unless directed otherwise in writing by my physician, medication will be administered as directed by package labeling. **Each medication must have your initials in either the "yes" or "no" box.** If you initial "no", we'll need to discuss a substitute option.

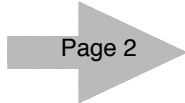
| | YES | NO |
|---|---------------------------------------|---------------------------------------|
| Ibuprofen (for pain, headache, fever, menstrual cramps)---- | <input type="text" value="Initials"/> | <input type="text" value="Initials"/> |
| Acetaminophen (for pain, headache, fever)----- | <input type="text" value="Initials"/> | <input type="text" value="Initials"/> |
| Calamine or Benadryl Spray(for itching, bug bites)----- | <input type="text" value="Initials"/> | <input type="text" value="Initials"/> |
| Cough Drops----- | <input type="text" value="Initials"/> | <input type="text" value="Initials"/> |
| Benadryl Elixir (allergic reaction to bite/sting)----- | <input type="text" value="Initials"/> | <input type="text" value="Initials"/> |
| Robitussin (for cough)----- | <input type="text" value="Initials"/> | <input type="text" value="Initials"/> |
| Sudafed (for colds, stuffy nose)----- | <input type="text" value="Initials"/> | <input type="text" value="Initials"/> |
| Claritin (for colds, stuffy nose)----- | <input type="text" value="Initials"/> | <input type="text" value="Initials"/> |
| Sunscreen----- | <input type="text" value="Initials"/> | <input type="text" value="Initials"/> |
| Collyrium Eye Wash (itching, irritation, chlorine)----- | <input type="text" value="Initials"/> | <input type="text" value="Initials"/> |
| Imodium AD (diarrhea)----- | <input type="text" value="Initials"/> | <input type="text" value="Initials"/> |
| Tums (upset stomach, nausea)----- | <input type="text" value="Initials"/> | <input type="text" value="Initials"/> |
| Dramamine (motion sickness)----- | <input type="text" value="Initials"/> | <input type="text" value="Initials"/> |
| Anti-Nausea Liquid (nausea)----- | <input type="text" value="Initials"/> | <input type="text" value="Initials"/> |
| Saline Nasal Spray (congestion, stuffy nose)----- | <input type="text" value="Initials"/> | <input type="text" value="Initials"/> |
| Honey (sore throat, coughing)----- | <input type="text" value="Initials"/> | <input type="text" value="Initials"/> |

I will be sending the following over-the-counter medications* (in the original container) for my child as needed:

- _____
- _____
- _____
- _____

* Please include creams, pain relievers, nasal sprays, eye drops, Midol, etc. Campers may keep no medications in their possession unless approved by the Director. This can be discussed with you prior to the start of camp

Signature of Parent/Guardian for this page _____ Date _____



Camper's Name _____

NOTE: Complete information and place your INITIALS in the appropriate boxes.

Has your child ever been/currently is under the care of a psychologist/psychiatrist/therapist? Initials No Initials Yes

If yes, explain: _____

DRUG ALLERGIES _____ Initials None known

FOOD ALLERGIES _____ Initials None known

ENVIRONMENTAL/INSECT/OTHER ALLERGIES _____ Initials None known

Is your child allergic to bee/insect stings? Initials Yes Initials Unknown - has never been stung

If previously stung, what type of reaction did he/she have? _____

Other Instructions _____

NOTE: If sending Epi-Pen: Camper must be able to administer their own Epi-Pen. **Two pens must be sent.**

INITIAL YES OR NO FOR EACH QUESTION:

Has your child ever: YES NO **If yes, explain below. Include approximate date(s).**

- 1. had a seizure? ----- Initials Initials _____
- 2. passed out? ----- Initials Initials _____
- 3. had a head injury/concussion? ----- Initials Initials _____
- 4. had difficulty breathing? ----- Initials Initials _____
- 5. suffered from heat problems? ----- Initials Initials _____
- 6. had heart problems? ----- Initials Initials _____
- 7. had bowel issues? ----- Initials Initials _____
- 8. had a broken bone? ----- Initials Initials _____
- 9. injured a joint? ----- Initials Initials _____
- 10. had mononucleosis? ----- Initials Initials _____
- 11. had measles and/or mumps? ----- Initials Initials _____
- 12. had chicken pox? ----- Initials Initials _____
- 13. had a bed wetting issue? ----- Initials Initials _____
- 14. had a bleeding/clotting disorder? --- Initials Initials _____

Does your child:

- 1. get motion sick? ----- Initials Initials _____
- 2. have skin problems? ----- Initials Initials _____
- 3. get frequent headaches? ----- Initials Initials _____
- 4. wear any appliance, eyeglasses
or contacts, braces, ear molds
or other protective device(s)? ----- Initials Initials _____
- 5. have dietary restrictions, lactose
intolerance or caffeine issues? ----- Initials Initials _____
- 6. have sleep issues? (Snoring,
restlessness, talking, walking) ----- Initials Initials _____
- 7. have asthma? ----- Initials Initials _____
- 8. use a nebulizer? ----- Initials Initials _____
- 9. use any medical device? ----- Initials Initials _____

Signature of Parent/Guardian for this page _____ Date _____