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)----	Initials	Initials
Acetaminophen (for pain, headache, fever)----------	Initials	Initials
Calamine or Benadryl Spray(for itching, bug bites)----------	Initials	Initials
Cough Drops----------	Initials	Initials
Benadryl Elixir (allergic reaction to bite/sting)----------	Initials	Initials
Robitussin (for cough)----------	Initials	Initials
Sudafed (for colds, stuffy nose)----------	Initials	Initials
Claritin (for colds, stuffy nose)----------	Initials	Initials
Sunscreen----------	Initials	Initials
Collyrium Eye Wash (itching, irritation, chlorine)----------	Initials	Initials
Imodium AD (diarrhea)----------	Initials	Initials
Tums (upset stomach, nausea)----------	Initials	Initials
Dramamine (motion sickness)----------	Initials	Initials
Anti-Nausea Liquid (nausea)----------	Initials	Initials
Saline Nasal Spray (congestion, stuffy nose)----------	Initials	Initials
Honey (sore throat, coughing)----------	Initials	Initials

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

1. _____
2. _____
3. _____
4. _____

* 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

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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_____