Wallace Junior Camp 2018

Wallace Presbyterian Church

3725 Metzerott Road - College Park, MD 20740 - 301 935-5900

MEDICAL AND EMERGENCY INFORMATION

CAMPER NAME:_____

This information form (to be filled out by the parent) and the "Physician and Order and Consent for Administration of Medication" form (on the back, to be signed by your doctor) or a comparable form provided by your doctor MUST be submitted to the Camp Director before departure for Camp in order for the camper to be permitted to receive prescription and over-the-counter medications at camp (if a parent is not present). Each and every medication must be supplied in an original pharmacy bottle or manufacturer's package and labeled with your child's name.

Check any of the following health problems your child may have:

Bed Wetting_____ Heart Condition_____ Kidney Condition _____ Seizures_____

Ear Infection_____ Fainting _____Diabetes_____ Sleep Walking_____

Psychiatric or Emotional Disorders_____

Does your child have ANY restrictions/limitations which would not allow him/her to fully participate in all camp activities? Yes_____ No_____ If yes, please be specific (Please do not wait until the day before Camp to tell us!)

_____

_____

Has your child had any serious operations or illnesses? Yes / No. If Yes, explain:

_____

_____

Are there any standard vaccinations that your child has NOT had, or from which they are exempt? Yes ____No____. If Yes, please list: _____

In Case of Emergency, I will assume obligation for the necessary expenses through my personal insurance policy. It is my understanding that primary insurance coverage is provided through my family medical policy. It will be necessary to pay care-givers at the time of service pending insurance claim processing. In case of emergency, I give my permission to the physician selected by the Camp Director or Administrator to secure proper treatment for my child.

Family Insurance Company: _____

Insurance Company Address: _____

Insurance Company Phone: _____Group#:_____ ID #:_____

Home Phone: _____ Work Phone: _____

Emergency Contact: _____ Phone: (_____) _____ Relationship: _____

Parent or Guardian Signature: _____

If your child has a communicable disease, please do not bring him or her to camp.

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Physician Order and Consent for Administration of Medication

Required at check-in with physician's signature

Camper's Name: _____Date of Birth: _____

Check allergic reactions to: Bee Stings_____ Hay Fever_____ Poison Ivy/Sumac/Oak_____

List any food allergies: _____

List any medication allergies: _____

1. List all medications with appropriate directions that your child receives on a routine/regular basis including all prescription, over-the-counter, and homeopathic medications. **(These items must be SUPPLIED BY PARENT, including Epi Pens and Inhalers)**

Medication	Dosage/Directions
1.	
2.	
3.	
4.	

2. Please check off any over-the-counter medications listed below which you will allow the camp nurse to administer to your child. **(These items will be PROVIDED in the Camp Nurse's Station, along with standard first-aid supplies.)**

For Headache/Fever /Earache/Muscle aches ❑ Acetaminophen (Tylenol) – 325 mg *Two tablets every 4 hours by mouth* ❑ Ibuprofen (Motrin) – 200 mg *One tablet every 4 hours by mouth*	**For Mild Allergic Reactions/ Rashes/ Insect Bites** ❑ Diphenhydramine (Benadryl) – 25 mg *Tablet or liquid by mouth. One tablet or dose every 6 hours* ❑ Hydrocortisone cream – 1.0% *Topically to skin twice daily*	**For Athlete's Foot/Jock Itch** ❑ Lotrimin Cream *Topically to skin twice daily* ❑ Tinactin spray powder *Topically to skin twice daily*
For Coughs/ Sore Throat ❑ Throat Lozenges ❑ Cough Syrup (Robitussin) *Dosage according to age/weight guidelines on package*	**For Gastrointestinal Upset** ❑ Pepto-Bismol *Oral dosage according to labeled guidelines* ❑ Maalox *Two tablet every two hours by mouth*	**For Minor Wounds** ❑ Neosporin ointment: *Topically* **For Contact Dermatitis (Poison Ivy/Oak)** ❑ Calamine Lotion: *Topically*

❑ I hereby give permission for my child to receive the named prescriptions, over-the-counter medications (or generic equivalent), and homeopathic medications checked above on this form. I understand that these medications will be administered by the camp director, camp administrator, or camp medical liaison (e.g. camp nurse).

❑ I do not want any medication given to my child at camp.

Parent / Guardian Signature: _____ Date: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Physician (Printed): _____ Office Phone: _____

Physician Signature: _____ Date: _____

I understand that if my child has a fever, the camp director, administrator, or designee will telephone me and may require my child to be picked up from camp.