

HEALTH HISTORY AND PERMISSION FORM
BOTH SIDES MUST BE COMPLETED AND SIGNED FOR TRIP ATTENDANCE

NAME OF CHILD _____ BIRTHDATE _____ AGE _____ SEX _____

NAME OF PARENT(S)/GUARDIAN _____

HOME TELEPHONE NUMBER OF PARENT(S)/GUARDIANS _____

FATHER'S WORK # _____ MOTHER'S WORK # _____

EMERGENCY CONTACT _____
(NAME/RELATION) (HOME PHONE) (WORK PHONE)

CHILD'S DOCTOR _____
(NAME) (PHONE)

CHILD'S DENTIST _____
(NAME) (PHONE)

MEDICAL/HOSPITAL INSURANCE CARRIER _____

POLICY/GROUP INFORMATION _____

Is your child subject to:

Constipation _____ Bedwetting _____ Sleepwalking _____ Asthma _____

Severe poison ivy _____ Severe bee/insect sting reaction _____

Allergies (list including drug allergies) _____

Any disabilities or serious illness: _____

Any dietary modifications needed: _____

Any past serious injuries or operations : _____

Date of child's last tetanus shot: _____

AUTHORIZATION TO GIVE EMERGENCY MEDICAL TREATMENT AND FOR RELEASE OF INFORMATION

I hereby grant permission for emergency medical treatment, by a licensed physician, for my child in case of illness or injury and grant permission for the release of any information requested for the completion of medical/surgical or accident insurance claims on my child. I assume full financial responsibility for medical services rendered.

Signature of Parent/Guardian

Date

PLEASE COMPLETE THE BACK PAGE

he following medications will be sent with my child:

- Please give all medications to the nurse just prior to leaving for the expedition. If you want your child to have a particular medication with them at all times (i.e. an inhaler) please list it, but indicate as such. This will mean, however, that the nurse will not be administering that particular medication to your child and therefore may not be able to fully monitor and assess the condition for which the medication was prescribed.

Medication	Dosage and Directions	Illness/Condition
_____	_____ _____ _____	_____
_____	_____ _____ _____	_____
_____	_____ _____ _____	_____
_____	_____ _____ _____	_____

ALL MEDICATIONS MUST BE IN THE ORIGINAL CONTAINERS, MARKED WITH YOUR CHILD'S NAME. PRESCRIPTION MEDICATIONS MUST BE IN A CONTAINER WITH PHARMACY LABEL. MEDICATION NOT CONFORMING TO THESE REGULATIONS WILL NOT BE GIVEN.

I hereby give permission for the camp nurse, or other authorized adult, to administer, as necessary, the following "over the counter" medications (**cross out exceptions**); cough syrup, acetaminophen (Tylenol), ibuprofen (Advil), Natural Tears eye drops, antihistamine and/or decongestant, antacid, hydrocortisone cream and the medications which I send with my child.

Signature of Parent/Guardian

Date

Put any other information that might be helpful:

