

Solid Rock Day Camp
CAMPER HEALTH FORM & MEDICATION RELEASE

Please return fully completed form (both sides)

Camper Name: _____

Emergency Contacts - Parent/Guardians

(1) Name (first, last) _____ (2) Name (first, last) _____

In priority order list what phone number to call in an emergency.

<u>No.</u>	<u>Phone Type</u>	<u>Name/Relationship</u>	<u>No.</u>	<u>Phone Type</u>	<u>Name/Relationship</u>
1 st # _____	_____	_____	2 nd # _____	_____	_____
3 rd # _____	_____	_____	4 th # _____	_____	_____

If parent/guardian not available in emergency, child may be released to: Name _____ Phone _____

Camper's Medical Providers:

Insurance Carrier _____ Account Number _____

Physician _____ Phone _____ Town _____

Dentist _____ Phone _____ Town _____

Orthodontist _____ Phone _____ Town _____

1. Please provide us with the following information: Any current health problems, on any medications, or any other information regarding family or health that would help us.

2. Does the camper have any of the following allergies: ___ None ___ Yes (indicate below)
 Asthma Hay fever Penicillin Dairy Soy Wheat Peanuts Tree Nuts Insect Stings Bee Stings Other _____

3. Activity Restriction – Should camper be excluded from any camp activities? Please explain.

4. Name of doctor and date of most recent physical exam _____ Date _____

Immunization Records: The State of NJ requires that we have on record the month/day/year of each immunization. **Dates must be filled out each summer (photo copy of doctor's record accepted). Information must be complete/in full for your child to attend camp.**

DPT: 1) ___/___/___ 2) ___/___/___ 3) ___/___/___ 4) ___/___/___ 5) ___/___/___ 6) ___/___/___

POLIO: 1) ___/___/___ 2) ___/___/___ 3) ___/___/___ 4) ___/___/___ 5) ___/___/___ 6) ___/___/___

HEP-B: ___/___/___

MMR: 1) ___/___/___ 2) ___/___/___ Measles ___/___/___ Mumps ___/___/___ Rubella ___/___/___

HIB: 1) ___/___/___ 2) ___/___/___ 3) ___/___/___ 4) ___/___/___

TB: 1) ___/___/___ 2) ___/___/___ Date of Latest Tetanus (must be completed) _____

Has the camper had any of the following: Measles German Measles Hepatitis A Hepatitis B Hepatitis C Chicken Pox Mumps

Emergency and General Release (Important – This area must be completed):

After attempts to reach me (parent/guardian) have not been successful, I hereby give permission to the medical personnel selected by the camp director to provide routine health care; to administer medications; 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 physician selected by the camp director to secure and administer treatment (dental and/or medical), including medical transportation, hospitalization, for the person named above. As parent/legal guardian I am responsible for the health care decisions of my child and am authorized to consent to the services to be rendered. I represent that my consent to and agreement to pay (personally or through my health insurance carrier) for the dental, medical, or hospital care or treatment to be rendered to my child is legally sufficient and that no consent from any other person is required by law. This completed form may be photocopied for trips out of camp.

Solid Rock Day Camp is licensed by the New Jersey State Department of Health, and is inspected annually. Inspection reports are filed in the Camp office.

Name of Parent/Legal Guardian (PRINT): _____ **Date:** _____

Signature of Parent/Legal Guardian: _____

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Please return fully completed form (both sides)

By NJ State law, Solid Rock Day Camp must have parental/guardian authorization to administer any prescription or non-prescription medications. Therefore, please complete the following release form and send it in with your application.

Name of Camper: _____

I do do not give permission for the camp nurse to administer Tylenol[®] (acetaminophen) if necessary.

I do do not give permission for the camp nurse to administer Advil[®] (ibuprofen) if necessary.

Name of Parent/Legal Guardian (PRINT): _____ Signature: _____ Date: _____

Nursing staff may not administer ANY other medications without a doctor's order including over-the-counter items such as eardrops, cortisone cream, etc.

Prescription & other Medication Release:

Please note the following:

1. All medication shall be labeled and stored in the original prescription container and in accordance with manufacturers' instructions.
2. Fill in the following medication release form in full and provide form and medications to group counselor. All medications will be administered from the camp office by qualified staff.
3. If medications must be returned nightly please indicate this below so that they can be given to your child at the end of the day.
4. Medications will be returned at the end of your child's stay.

Name of Parent/Legal Guardian (PRINT): _____ Signature: _____ Date: _____

Medication name: _____

Condition for which the medication is being used: _____

Cautionary Information: _____

Side effects or precautions we should know about: _____

Instruction for administration (including dosage & frequency): _____

Prescribing Doctor: _____ Phone #: _____

Does medication have to be returned nightly for use at home? **YES NO** or on **FRIDAY**

Official Camp Use Only

Person administering medication: _____ Signature: _____

	Mon.	Initials	Tue.	Initials	Wed.	Initials	Thu.	Initials	Fri.	Initials
Date										
Time am/pm										
Date										
Time am/pm										

Use for notes and recordings of any medication error, adverse drug reactions and/or notes from contacting doctor; date/initial all comments.
