This section *must* be completed by a parent/guardian OR the child's primary physician.

CHILD'S HEALTH HISTORY

Allergies: _____ Treatment: _____

Allergies: _____ Treatment: _____

Allergies: _____ Treatment: _____

Dietary modifications:

_____

Disabilities:

_____

Chronic/recurring illnesses:

_____

Current medications:

_____

Activity limitations:

_____

Any other known physical or mental conditions:

_____

Name of Physician: _____ Phone (____) _____

Physician's address:

_____

Date of last physical examination _____

Is there anything else we should know about your child to provide your family with the best service possible?

_____

_____

The Health History is correct, so far as I know, and the person herein described has permission to engage in all prescribed activities except as noted. _____ *initial*

Emergency Authorization: I hereby give permission to medical personnel to order X-rays, routine tests, and treatment for me/my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician to hospitalize, secure proper treatment for, and to order injection, anesthesia, and/or surgery for me/my child as named above. This form may be photocopied.

_____ _____

Signature of Parent/Guardian Date

PLEASE NOTE: EVEN IF YOUR CHILD DOES NOT NEED TO BE ADMINISTERED MEDICATION, PLEASE SIGN BELOW THAT YOU HAVE READ AND RECEIVED THIS INFORMATION. THANK YOU!

Medication/Treatment Authorization

State licensing requirements permit day camp facilities to administer medications under the following guidelines:

1. All medications shall be administered only on the written approval of a parent/guardian.
2. Prescription medications shall be administered only as directed on the label or as otherwise authorized by a physician.
3. Prescription medications shall be administered only as directed on the label or as otherwise authorized by a physician. **Over the counter medications will be administered only with a medical doctor's written orders.**

Please provide the following information:

Child's Name:

_____

Medical Problem(s):

_____

Is the problem chronic or ongoing? ○ YES ○ NO

Name of Medication: _____ Amount: _____

Method of Administration:

_____

IF YOUR CHILD DOES NOT REQUIRE MEDICATION, PLEASE READ AND SIGN BELOW

I hereby acknowledge that my child DOES NOT need to be administered any medications at this time.

PARENT SIGNATURE _____ DATE