**CAMP STRAWDERMAN**
**Health Certificate**
**To be Filled out by Parents**

**Name of Camper:** _____ **Birthdate**: _____ **Age**: ____

**Home Address**: _____
*Street* *City* *State* *Zip code*
**Parent or Guardian**: Name_____
(H)_____ (W)_____ (C)_____

**Second Parent or Guardian:** Name_____
(H)_____ (W)_____ (C)_____

**Alternate/Emergency Contact**: Name_____
Relationship_____ (H)_____(C)_____

**MEDICAL CONDITIONS: Please include explanation of condition if indicated.**
( ) This camper has NO health problems.

( ) ADHD ( ) Asthma ( ) Bedwetting ( ) Recent concussion ( ) Diabetes ( ) Eczema
( ) Ear Infections/Tubes ( ) Heart Problems ( ) Insect Sting Reaction ( ) Mental Health Issue
( ) Migraines ( ) Orthopedic Issues ( ) Poison Ivy ( ) Seizures ( ) Other _____

Explanation: _____
Activity Restrictions: _____
Suggestions to help your daughter have a happy, healthy summer: _____
_____

**MEDICATIONS: Please list ALL medications including vitamins, over-the-counter medications, supplements, etc. If you anticipate your daughter to require regular dosing of over-the-counter medication, please send an adequate supply to camp with your daughter.**

1.Name of med_____ Dosage _____ Time taken _____
2.Name of med_____ Dosage _____ Time taken _____
3.Name of med _____ Dosage _____ Time taken _____
4.Name of med _____ Dosage _____ Time taken _____
5.Name of med _____ Dosage _____ Time taken _____

**ALLERGIES: Please describe reaction.**
Medications _____
Foods _____
Seasonal/Environmental _____
**CONSENT FOR OVER-THE-COUNTER MEDICATION: The infirmary stocks several OTC meds which will be dispensed when medically necessary as per the camp nurse. Please CROSS OUT those medications your daughter SHOULD NOT be given.**

Acetaminophen (Tylenol) Bactine (antiseptic) Calamine Chloraseptic Throat Spray Clotrimazole (antifungal) Dayquil (acetaminophen/DM/phenylephrine) Diphenhydramine (Benadryl) Hydrocortisone 1% cream Guaifenesin DM (cough syrup) Ibuprofen (Motrin) Immodium (antidiarrheal) Loratadine (Claritin) Maalox Miralax (laxative) Nyquil (acetaminophen/DM/doxylamine) Pseudoephedrine (Sudafed) Triple Antibiotic Ointment Tums

**CONSENT FOR PREVENTIVE SWIMMER'S EAR DROPS:**
I give permission for my daughter to have preventive ear drops (made of rubbing alcohol and vinegar solution) after swimming activities to prevent swimmer's ear. CIRCLE ONE ( yes / no )

**DOCTOR INFORMATION:**
Name of camper's doctor: _____
Phone number: _____

**INSURANCE INFORMATION:**
Is the camper covered by health insurance? ____ Carrier _____ Group #_____
**PHOTOCOPY FRONT & BACK OF HEALTH INSURANCE CARD AND ATTACH TO FORM**

**PARENT'S AUTHORIZATION & PERMISSION TO TREAT:**
I certify that this Health Certificate and the Camper's medical history are correct and complete to the best of my knowledge. The Camper herein named has permission to engage in all camp activities except as noted by parent/guardian or physician.

I hereby give permission to the camp to provide, seek, and consent to routine health care, including, but not limited to, first aid and symptomatic treatments for minor conditions, including over the counter medications, as limited herein, administration of prescribed medications, and emergency care for my child as may be necessary, including, but not limited to, x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

It is my intention that the camp be treated as acting *in loco parentis* if the Camper herein named is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the purposes of disclosing protected health information pursuant to the privacy regulations of the Health Information Portability and Accountability Act (HIPAA). I hereby agree that I have disclosed to camp representatives, as necessary: (I) all relevant information to the Camper's ability to participate in camp activities, (II) all relevant information regarding the Camper's health history and (III) all information necessary to keep me informed of my child's health status.

In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for my child.

SIGNATURE of parent/guardian _____
Printed name _____ Date _____

**CAMP STRAWDERMAN**
**Health Certificate**
**To be Filled out by Physician**

**MEDICAL EXAMINATION: This must be completed by licensed health care professional that has seen and examined this patient in the last 12 months.**

**Date of physical exam: _____**

****PLEASE ATTACH A COPY OF CHILD'S IMMUNIZATION RECORD****

**Weight: _____ Height: _____ Blood Pressure: _____**

In your opinion, is the above applicant able to participate in an active camp program including horseback riding and swimming? _____

Please list any medical or psychiatric conditions for which this child is receiving care by a health care professional. _____
_____
_____

Treatments or Medications to be continued while at camp. _____
_____
_____

Known allergies. Please describe reactions. _____
_____
_____

Medically prescribed meal plan or dietary restrictions. _____
_____

Description of any limitation or restriction on camp activities. _____
_____
_____

**PHYSICIAN SIGNATURE: _____ TITLE: _____**

**PRINTED NAME: _____ DATE SIGNED: _____**

**ADDRESS: _____**

**PHONE NUMBER: _____**