REHOBOTH BAPTIST CAMP
MEDICAL FORM

Please fill out all information below to the best of your ability, so that we will be able to take the best care of your child.

CAMPERS INFORMATION:

Name:_____________________________________ DOB____________________________

Address:____
____

Phone Number_______________________

PARENT/GUARDIAN INFORMATION:

Name:____

Work Phone:_____________________ Cell Phone:_______________________

Home Phone:_____________________

EMERGENCY CONTACTS:

Name:______________________________ Home Phone__________________

Cell Phone:__________________________

Name:______________________________ Home Phone___________________

Cell Phone:__________________________

MEDICAL INFORMATION:

Medical Doctor:_______________________ Phone:_________________________

(OVER)

ALLERGIES:

Medications:____

Insect/bites(bees, wasps, etc.)____

Foods(Peanuts, strawberries, etc.)____

Latex:________________________________

Plants(poison ivy, etc.)____

IMMUNIZATIONS:
Are your child's immunizations up to date? YES NO
Last Tetnus:____________________

Below is a list of medical problems, please check yes or no to the following:

	YES	NO
Asthma	___	___
ADHD	___	___
Cancer/Leukemia	___	___
Seizures/epilepsy	___	___
Diabetes	___	___
Heart trouble	___	___
High Blood Pressure	___	___
Over heats easily	___	___
Sleep Walks	___	___
Bed Wetting	___	___

Other:____

Please explain why you marked YES:_________________________________

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REHOBOTH BAPTIST CAMP
PERMISSION TO ADMINISTER MEDICATIONS

I, the parent/guardian of ___________________________give my permission to the camp Health Care Provider of his/her designate to give the following medications (or their generic equivalents) to my child, in accordance with recommended package dosing for the specific indications below. These medications are available at the camp and CAMPERS NEED NOT BRING THEM TO CAMP.

PLEASE CHECK BELOW WHAT YOUR CHILD IS ALLOWED TO RECEIVE.

	YES	NO
Tylenol: Mild fever or discomfort	___	___
Ibuprofen/Motrin: Mild fever or discomfort	___	___
Throat Lozenges: Cough/sore throat	___	___
Topical Creams: Itching, sunburn, or Insect bites	___	___
Benadryl: Allergy symptoms	___	___
Antacid (Tums, Pepto-Bismol):upset stomach	___	___
Anti-diarrheal: for diarrhea	___	___
Sunscreen: Sunburn protection	___	___
Insect Repellent	___	___

Signature of Parent/Guardian:_____________________________________Date:____________________

Please list all medications (including over the counter or non- prescription drugs)taken routinely. Bring enough medication to last the entire week of camp. Please keep the medication in its ORIGINAL PACKAGE/BOTTLE that identifies the name of the medication, the dosage and the frequency of administration.

I, the parent/guardian of _________________________give my permission to the camp Health Care Provider or his/her designate to give the following medications to my child.

Med#1___________________________ Med#7________________________________
Med#2___________________________ Med#8________________________________
Med#3___________________________ Med#9________________________________
Med#4___________________________ Med#10_______________________________
Med#5___________________________ Med#11_______________________________
Med#6___________________________ Med#12_______________________________

ALL MEDICATIONS BROUGHT TO CAMP MUST BE IN THE ORIGINAL CONTAINERS!!

Signature of parent/guardian:__________________________________Date:_______________________