Cabin # _____ (staff will fill out) **Counselor Name: _____(staff will fill out)**

River of Life Ministries Camp Medical Form

Camper Name: _____ DOB: _____ Age: _____ Male / Female (circle)

ALLERGIES _____

*Please note we will only provide campers with **Tylenol**, **Ibuprofen**, and **Benadryl**. Any other medications (prescription, over the counter or vitamins) **MUST** come from home in their original bottle. (Ex: Claritin for seasonal allergies) Please do not send medications in a "days of the week" container. They will not be given and you will be called to camp to provide original bottles or you will have to come each time a med is due to administer yourself if unable to provide original bottle. R.O.L.M. will not be held responsible for administering unlabeled medications.

Please initial that you have read the above paragraph and are in agreement: _____

Permission to give as needed medication:

I give R.O.L.M. permission to give said camper Tylenol _____, Ibuprofen _____, and/or Benadryl _____ as needed according to medication guidelines. **Please initial each medicine that is OK to give**.

Parent / Guardian Signature: _____ Date: _____

Parent / Guardian Phone Number: _____

Emergency Contact Name: _____ Phone: _____

***Emergency contact will only be called if a parent / guardian cannot be reached first.**

****Campers will be checked for head lice by nurse: _____ (**Must be done before camper enters a cabin**)

Prescription Medications	Purpose or Reason Taking	DOSE	Time(s) Of Day	Form (Liquid, capsule, tablet)	Special Instructions