CAMP CEDAR CREST MEDICAL FORM

Parent/Guardian please <u>initial</u> in provided space to acknowledge you have read important information.

_____ Initial **<u>NO</u> CAMPER WILL BE ALLOWED TO ATTEND CAMP WITHOUT A COMPLETED MEDICAL FORM.**

_____ Initial **<u>NO</u> MEDICATION WILL BE GIVEN TO A CAMPER BY ANY MEDICAL PERSONAL IF MEDICATION IS NOT IN IT'S ORIGINAL PRESCRIBED CONTAINER.**

<u>NO</u> PRE-FILLED/POURED MEDICATIONS WILL BE ALLOWED.

*PLEASE FILL IN ALL BLANKS OR CIRCLE CORRECT ANSWERS, **PLEASE PRINT**.*
***INITIAL** WHERE INDICATED BY PARENT OR GUARDIAN.*

_____ Male / Female _____ ___/___/_____
(Camper's Name) (Gender) (age) (Date of Birth)

EMERGENCY CONTACT INFORMATION

1st Contact Phone #	Name	Relationship
2nd Contact Phone #	Name	Relationship
3rd Contact Phone #	Name	Relationship

MEDICAL HISTORY AND CONDITIONS

_____ Initial DATE OF LAST TETANUS SHOT_____

DOES YOUR CHILD HAVE ANY:

Allergies	Yes	No	Diabetes	Yes	No
Seizures	Yes	No	Behavior Problems	Yes	No
Bed Wetting	Yes	No	Other	Yes	No

If you answered YES *to any of the above, explain:*

_____

MEDICATIONS

Does your child take any prescription ***or*** over the counter drugs which need to be dispensed during camp? **YES NO**
(If you answered YES, please list below)

MEDICATION	DOSAGE	AMOUNT TO BE GIVEN	TIME OF DAY
1.			
2.			
3.			
4.			

Please continue on back if needed

ALL MEDICATIONS MUST BE TURNED INTO MEDICAL PERSONEL AT TIME OF REGISTRATION. THIS INCLUDES ALL OVER THE COUNTER MEDIATIONS;

NO MEDICATIONS ARE TO BE IN CABINS.

BY SIGNING BELOW, I GIVE MY PERMISSION TO THE CAMP MEDICAL PERSONEL TO ADMINISTER THE CHECKED OVER THE COUNTER MEDICATIONS TO MY CHILD AS THEY DEEM NECESSARY:

___ All medications listed
___ Ear drops (pain control)
___ Ear drops (swimmer's ear)
___ Tylenol liquid or tablets
___ Ibuprofen liquid or tablets
___ Cough medicine
___ Cold sore medication
___ Benadryl liquid or caplets
___ Anti-itch creams
___ Neosporin ointment
___ Tums
___ Pepto-Bismol
___ Acid control tabs
___ Orajel
___ Throat lozenges

X _____ _____

Parents or Guardian Signature Date

BY SIGING BELOW, I GIVE MY PERMISSION TO THE CAMP MEDICAL PERSONNEL TO TRANSPORT MY CHILD TO THE AUDRAIN MEDICAL CENTER E.R. IN MEXICO, MO (573-582-4000) FOR ANY MEDICAL EMERGENCY TREATMENT NEEDED.

I ALSO GIVE MY PERMISSION TO AUDRAIN MEDICAL CENTER TO PROVIDE EMERGENCY TREATMENT TO MY CHILD AS DEEMED NECESSARY BY THE ATTENDING EMERGENCY ROOM PHYSICIAN.

X _____ _____

Parents or Guardian Signature Date

NOTE: THE PARENT OR GUARDIAN WILL BE NOTIFIED OF THEIR CHILD'S NEED FOR EMERGENCY MEDICAL TREATMENT BEFORE TRANSPORT (IF TIME PERMITS). YOU WILL BE NOTIFIED AS SOON AS CHILD IS IN THE E.R.

INSURANCE

_____ _____ _____

Insurance Company Policy/Group # Phone #

It is the policy of the Cedar Crest Camp Board that the Camp Board insurance will cover treatment for all campers and staff that is not covered by their personal insurance. Any personal insurance will be the primary insurance.