

All information will be held in the strictest confidence; please be as thorough as possible.

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Date \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

Blood Pressure \_\_\_\_\_ Urine \_\_\_\_\_ Hematocrit \_\_\_\_\_

Mother's Name: _____	Father's Name: _____
Mother's Phone#(house): _____	Father's Phone#(house): _____
Mother's Phone#(cell): _____	Father's Phone#(cell): _____
<b>Emergency Contact #1</b>	
Name: _____	Relationship: _____ Phone # _____
<b>Emergency Contact #2</b>	
Name: _____	Relationship: _____ Phone # _____
<b>Emergency Contact #3</b>	
Name: _____	Relationship: _____ Phone # _____

**Health Care Recommendations by Licensed Physician**

**\*The Health Department requires that a physical exam was completed no more than a year prior to the last day of camp, 8/21/20.**

**Date of Last Physical Exam: \_\_\_\_\_**

Is the camper able to participate in an active camp program? \_\_\_\_\_ Yes \_\_\_\_\_ No

Camper is under the care of a physician for the following condition(s): \_\_\_\_\_

Current treatment (include current medications): \_\_\_\_\_

Explanation of any reported loss of consciousness, convulsion, or concussion: \_\_\_\_\_

Child's name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Are there any...**

Allergies (food, drugs, plants, insects, etc)? If yes, please explain: \_\_\_\_\_

If yes, should exposure occur, how should the allergic reaction be treated? \_\_\_\_\_

If this is an anaphylactic response, will this child's parents supply an epinephrine device? \_\_\_\_\_

Cardiovascular conditions? \_\_\_\_\_

Respiratory conditions? \_\_\_\_\_

Middle ear conditions? \_\_\_\_\_

Gastrointestinal conditions? \_\_\_\_\_

Neurological conditions? \_\_\_\_\_

**Are there any...**

Activity restrictions? \_\_\_\_\_

Orthopedic conditions? \_\_\_\_\_

Special diet? \_\_\_\_\_

Treatment(s) to be continued at camp? \_\_\_\_\_

Medication(s) to be administered at camp? \_\_\_\_\_

Same as during the school year? \_\_\_\_\_

Additional medical or psychological conditions not listed that we should be aware of? \_\_\_\_\_

Child's name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Camper Immunization History**

Please record the date (month and year) of basic immunizations and most recent booster doses.

Vaccines	Year of Basic Immunization	Year of Last Booster
DPT Series, Diphtheria, Pertussis, Tetanus OR	1 2 3	1 2 3
TD Series, Tetanus, Diphtheria OR		
Tetanus		
Polio Series		
MMR Series		
HIB Series		
Hepatitis B Series		
Chicken Pox (illness or vaccine)		
Meningitis		
Other		

**\*\*A copy of the immunization report from your child's physician may be attached to this paper.**

**We may have neglected to ask something you feel is needed to adequately address the health needs of this child. If that is the case, please add your comments.** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Licensed Physician's Name \_\_\_\_\_

Physician's Signature \_\_\_\_\_

Physician's Address \_\_\_\_\_ Phone \_\_\_\_\_

Date of Form Completion \_\_\_\_\_ \*By \_\_\_\_\_

*\*Initial if completed by nurse or physician's assistant.*



## PRN Over -The -Counter Medications

Camper Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

PRN medications are over-the-counter medications that can be administered by camp medical personnel if approval is indicated by a camper's healthcare provider or parent. Administration, dosage, and schedule of the following medications will be determined based on the manufacturer's instructions as appropriate for the camper's age, weight, etc. unless otherwise specified on this form.

Generic equivalents of the following medications may also be given. Please indicate if your child is allergic to any generic or name-brand medication.

Medication Over-The-Counter	Administration	Alternate Medication or Special Instructions
Bacitracin/Neosporin	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hydrocortisone Cream/Ointment	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Saline/Eye Wash	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hydrogen Peroxide	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Rubbing Alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Benadryl Itch Stopping Gel	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Calamine Lotion	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**\*\*\*PLEASE COMPLETE AND RETURN TO THE CAMP OFFICE BY May 1<sup>ST</sup>.\*\*\***



## Prescription Medications

Camper Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Please have your child's physician fill out this form if you wish Malibu Beach Camp medical personnel to administer a prescribed medication to your child that is not on the PRN Over The Counter Medications List (i.e. Epi-Pen, Inhaler, Benadryl, etc.)**

I \_\_\_\_\_ (Parent's name), give permission to Malibu Beach Camp medical personnel to administer \_\_\_\_\_ (medication name)  
\_\_\_\_\_ (medication name) \_\_\_\_\_ (medication name)

to my child under the following circumstance: \_\_\_\_\_.

The dosage that should be given is:

\_\_\_\_\_.

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Physician's Signature: \_\_\_\_\_

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