

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): _____
Emergency Contact #1	
Name: _____	Relationship: _____ Phone # _____
Emergency Contact #2	
Name: _____	Relationship: _____ Phone # _____
Emergency Contact #3	
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, 8/20/22.**

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 1st.*****



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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