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, 8/18/23.**

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	☐ Yes ☐ No	
Hydrocortisone Cream/Ointment	☐ Yes ☐ No	
Saline/Eye Wash	☐ Yes ☐ No	
Hydrogen Peroxide	☐ Yes ☐ No	
Rubbing Alcohol	☐ Yes ☐ No	
Benadryl Itch Stopping Gel	☐ Yes ☐ No	
Calamine Lotion	☐ Yes ☐ No	

Parent's Signature:__________________________________ **Date:** _______________

******PLEASE COMPLETE AND RETURN TO THE CAMP OFFICE BY May 1st.*****

Prescription Medications

Camper Name: ___________________________________ Date of Birth _______________

<u>Please have your child's physician</u> 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: ____________

******PLEASE COMPLETE AND RETURN TO THE CAMP OFFICE BY May 1st.*****