DURANGO MOUNTAIN CAMP - Camper Medical Information

Camper Name _____ Date of Birth _____

Home Phone_____ Mother's Cell Phone_____ Father's Cell Phone_____

Please circle one: Child lives with: Mother Father Both

Pediatrician _____ Phone_____

Insurance Carrier _____ Policy #: _____

Please include a copy of your child's insurance card (front and back), and a copy of your credit card (front and back). The medical clinic will not accept a patient without this information.

Will your child have any special needs while at camp? Please be specific.

_____

In the event that I cannot be reached during an emergency I give consent for Durango Mountain Camp to secure proper medical treatment

_____ _____

Signature of parent **Date**

This portion to be completed by your physician:

1. Does this child have a health condition, which may require emergency action while he/she is at camp (e.g. seizures, bleeding problems, diabetes, heart problems, asthma, and allergies)? Yes No

If YES, please explain: _____

_____

_____

2. Does this child need an Epipen available? YES NO
If YES, please advise parent to supply two Epipens to the camp.

3. Except as previously noted, this child is otherwise in good physical and mental health, is free of communicable disease, and may participate fully in all activities. YES NO
If no, specify if this is a blanket denial or related only to specific camp activity (e.g. swimming, hiking, biking, climbing, horseback riding, kayaking, etc.).

_____

4. Is this child on any medication? YES NO If YES, please complete the Medication Order Form for each medication to be administered – both prescription and over-the-counter drugs.

_____ _____

Physician's name – please print **Signature of physician**

Camper Medical Information

Dear parents,

ALL DRUGS MUST COME WITH A DOCTOR'S ORDER. Advise your camper that all medicine will be kept in the Camp Office under the supervision of the Camp Director. Please take this form to your physician and have him/her record instructions regarding the administration of your child's medication. **PLEASE PUT THE ENTIRE 6 WEEKS SUPPLY OF MEDICATIONS IN MEDICAL DISPENSING BOXES.** Thank you.

Name of Child _____ Primary Phone #: _____

PRESCRIPTION DRUGS

1. Drug name_____Dosage_____

Time and circumstances of administration: _____

Can a reaction be expected? _____ If so, explain_____

2. Drug name_____Dosage_____

Time and circumstances of administration: _____

Can a reaction be expected? _____ If so, explain_____

3. Drug name_____Dosage_____

Time and circumstances of administration: _____

Can a reaction be expected? _____ If so, explain_____

OVER-THE-COUNTER DRUGS (Tylenol, Benadryl, Advil, Pepto-Bismol, etc. – may be needed at camp**? If a medication is not listed below, then the camp will not be able to administer a medication requested by your child**.)

4. Drug name_____Dosage_____

Time and circumstances of administration: _____

Can a reaction be expected? _____ If so, explain_____

5. Drug name_____Dosage_____

Time and circumstances of administration: _____

Can a reaction be expected? _____ If so, explain_____

_____ _____

Physician's name – please print **Signature of physician**

_____ _____

Signature of Parent **Date**

1/09