

Camper's Name & Birthdate: \_\_\_\_\_

Weekend: \_\_\_/\_\_\_/\_\_\_ - \_\_\_/\_\_\_/\_\_\_

Knowing and understanding your camper's medical history helps us to provide the best care possible to your camper. Please check the boxes below if your camper has any known diagnosed medical conditions Midcourse staff should be aware of. Use the lines below or an extra sheet of paper if you need more space to explain.

- My camper has no known/diagnosed medical conditions
  - Asperger's
  - Autism
  - ADD
  - ADHD
  - Learning disability (if yes, please specify: \_\_\_\_\_)
  - Anxiety
  - Depression (including suicidal ideations/attempts: \_\_\_\_\_)
  - Eating Disorder (if yes, please specify: \_\_\_\_\_)
  - Other psychiatric/behavioral disorders (if yes, please specify: \_\_\_\_\_)
  - Diabetes
  - Seizure Disorder (if yes, please list type and date of last seizure: \_\_\_\_\_)
  - Asthma (if yes, please specify any triggers: \_\_\_\_\_)
  - Cardiac (heart) Conditions (if yes, please specify: \_\_\_\_\_)
  - Any current injury or illness requiring stitches/casts/splints/etc (if yes, please specify: \_\_\_\_\_)
  - Other medical conditions (if yes, please specify: \_\_\_\_\_)
- Additional space: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Does the camper have any allergies? (Yes/No)

Any food/dietary restrictions? (Yes/No) If yes, please list: \_\_\_\_\_

Please list any allergies your camper has and their reaction to the allergen (use additional paper if necessary):

	List	Type of Reaction (e.g. hives, anaphylaxis, etc)
Food		
Medication		
Environmental		

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Please complete this form even if your child does not take any prescription medications. Please list all medication that your child will need to take during the weekend camp, if any. The medical officer will oversee administration of all medications; campers **are not allowed** to keep any medications on them or in their gear. Please send enough medication for the entire weekend at camp in the original package/bottle that identifies the prescribing physician, the name of the camper, the name of the drug, the dosage, and the frequency at which it must be taken. Prescription medications **will only be accepted with the original prescription container**. This includes rescue inhalers. If medications are brought in any container other than the original, you will be asked to visit the local pharmacy to obtain a copy of the prescription at your own time and expense. Pill boxes for dispensing are okay, however, **the original prescription must also be present**. Medications are given at mealtimes and bed; please make a note and speak with the medical officer at registration if medications must be given at other specific times.

____ Please initial here if the camper has no prescription or OTC medications that will be provided to the medical officer or must be taken while at camp				DO NOT MARK IN THIS COLUMN; FOR MEDICAL OFFICER USE ONLY								
Medication	Dosage	Description		Friday		Saturday				Sunday		
				Dinner	Bed	Breakfast	Lunch	Dinner	Bed	Breakfast	Lunch	
Example: Adderall	5 mg tablet	Reason	ADHD	Camper	Camper	Camper	Camper	Camper	Camper	Camper	Camper	Camper
		Frequency	1 at breakfast, 1 at dinner									
		Reason		Camper	Camper	Camper	Camper	Camper	Camper	Camper	Camper	Camper
		Frequency										
		Reason		Camper	Camper	Camper	Camper	Camper	Camper	Camper	Camper	Camper
		Frequency										
		Reason		Camper	Camper	Camper	Camper	Camper	Camper	Camper	Camper	Camper
		Frequency										
		Reason		Camper	Camper	Camper	Camper	Camper	Camper	Camper	Camper	Camper
		Frequency										
		Reason		Camper	Camper	Camper	Camper	Camper	Camper	Camper	Camper	Camper
		Frequency										
		Reason		Camper	Camper	Camper	Camper	Camper	Camper	Camper	Camper	Camper
		Frequency										
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		Frequency										
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		Frequency										
		Reason		Camper	Camper	Camper	Camper	Camper	Camper	Camper	Camper	Camper
		Frequency										

I, Parent/Guardian, confirm that the medication, dosage, and distribution information for (Camper's name) \_\_\_\_\_ is correct.

\_\_\_\_\_  
Printed Parent/Guardian Name

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

Camper's Name and Birthdate: \_\_\_\_\_  
 Weekend: \_\_\_/\_\_\_/\_\_\_ - \_\_\_/\_\_\_/\_\_\_

Medical officers are trained to provide basic first aid during the weekend. Below is a list of over-the-counter (OTC) medications the medical officer has available to your campers if/when they need it. All OTC medications will be given following manufacturer's recommendations. These are provided at no cost to you. By signing this form and sending your child to camp, you give the medical officers permission to administer OTC medications. If you do NOT want your camper to receive any of the below medications for any reason, please cross it off the list. Please note most oral medications are in pill/tablet/capsule form. Please note some medications are generic and some are brand name. If you have any questions, please call the office or come see the medical officer at registration.

	For Medical Officer Use Only				
	MO, please note dose, time, reason, and MO initials for any medications given				
<b>For Pain:</b>					
Acetaminophen (generic Tylenol)					
Ibuprofen (generic Motrin)					
Naproxen (generic Aleve)					
Menstrual Relief (generic Midol)					
<b>For Allergies:</b>					
Diphenhydramine (generic Benadryl)					
Fexofenadine (generic Allegra)					
Hydrocortisone Cream					
<b>For Gastrointestinal and Cold:</b>					
Pepto-Bismol					
Calcium Carbonate (generic Tums)					
MiraLax					
Acetaminophen/Dextromethorphan/Phenylephrine (generic DayQuil)					
<b>For Minor Cuts, Wounds, and Topical Treatment:</b>					
Sunscreen (brand varies)					
Aloe Vera Gel					
Insect Repellent (brand varies)					
Triple Antibiotic Ointment					
Hydrocortisone Cream					
Anti-fungal Cream					
Talcum Powder (generic Anti-Monkey Butt, Gold Bond foot powder)					
Poison Ivy cream (brand varies)					
Lip Balm (brand varies)					
Petroleum Jelly (generic Vaseline)					
Hydrogen Peroxide					
Isopropyl Alcohol					

I, Parent or Guardian, confirm that \_\_\_\_\_ (camper's name) \_\_\_\_\_'s medical information above is complete and accurate. My signature below authorizes the Midcourse Medical Officer to administer the OTC medications above following manufacturer's recommendations.

\_\_\_\_\_  
 Parent/Guardian Name (printed) and Signature

\_\_\_\_\_  
 Date