

Pennsylvania Christian Camp Health Form

To be completed and signed by parent or guardian.

Please print

Camper's Name _____ Date of Birth ___/___/___

Age ___ M ___ F ___

Parents' Names _____

Home Address _____

City State Zip

Home Phone () _____

Cell Phone () _____

Work Phones () _____

() _____

Family Physician _____

Physicians Phone () _____

Does your child currently take prescription or non-prescription medication on a regular basis? _____

If yes please list them along with times to be administered: _____

Will your child have medication that requires refrigeration? _____

"I give my permission to the camp nurse to administer the following medication to my child for the following complaints."

For headache, muscle ache, or sports injury:

Aspirin _____yes _____no

Acetaminophen _____yes _____no

Ibuprofen _____yes _____no

For upset stomach:

Antacid (Maalox) _____yes _____no

For severe allergic reaction

(swelling, itching, hives)

diphenhydramine (Benadryl) _____yes _____no

Contact lenses _____yes _____no

Tetanus Immunization Date: _____

Other information that would be helpful to the camp nurse while your child is at camp: _____

Does your child have :

Allergies: _____yes _____no

Asthma: _____yes _____no

Diabetes: _____yes _____no

Other:

Our family insurance coverage is _____

Policy # _____

I hereby authorize any representative of PCC to obtain any emergency medical treatment for my child that may be needed.

Parent/Legal Guardian's Signature

Date

***** Please attach a photo static copy of your health insurance card.**