Medical Information Form

Summer Recreation Camps

Personal Information

Camper's Name		Birth Date		Social Security No.	
Family Physician	Phone No.		Family Dentist		Phone No.
Medical Insurance Provider		Policy No.		Group No.	

***Immunization History-Campers immunization record is**
REQUIRED
Please Submit ENTIRE IMMUNIZATION RECORD

Please indicate if your child is taking any medications.
NOTE: Camp staff is not permitted to dispense medication.

Medication	Reason for Taking	Dosage	Time Taken
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Please indicate if you child has, or has ever had, any of the following conditions:

Y	N	Abdominal Pain	Y	N	Fatigue (chronic)	Y	N	Mononucleosis
Y	N	Anemia	Y	N	Head Injury	Y	N	Pneumonia
Y	N	ADD, ADHD	Y	N	Headaches (recurrent)	Y	N	Seizures
Y	N	Asthma	Y	N	Hearing Loss	Y	N	Sinus Infections
Y	N	Bronchitis	Y	N	Heart Disease, Murmur	Y	N	Skin Disorders
Y	N	Congenital Abnormality	Y	N	Hepatitis	Y	N	Tuberculosis
Y	N	Cancer	Y	N	High Blood Pressure	Y	N	Vision Problems
Y	N	Depression	Y	N	Immune Disease	Y	N	Urinary Tract Infection
Y	N	Diabetes	Y	N	Kidney Disease			
Y	N	Ear infections (chronic)	Y	N	Migraines			

Please complete the opposite side of this form

Please indicate if you child has, or has ever had, any of the following conditions and provide an explanation:

Y	N	Allergies to medications	
Y	N	Other allergies	
Y	N	Prior hospital admissions	
Y	N	Surgeries	
Y	N	Knee/ankle injuries requiring medical attention	
Y	N	Serious injuries that did not require hospitalization	
Y	N	Broken bones, fractures, or other dislocations	
Y	N	Unexplained loss of consciousness	
Y	N	Excessive absenteeism from school due to illness	
Y	N	Restricted physical activity due to illness or injury within 3 years	
Y	N	Treatment or counseling for any emotional or psychiatric problem within 3 years	
Y	N	Physical or emotional disability	
Y	N	Any other significant past medical history	
Y	N	Family or lifestyle changes within the past year	

Please provide any other pertinent medical information

Medical Release Statement

I hereby give my permission to the medial personnel selected by New Castle County and/or the Summer Recreation Camp Staff to order treatment and necessary transportation for my child on a routine or emergency basis. In the event I cannot be reached in an emergency, I hereby give my permission to the physician to secure and administer treatment, including authorization for my child named above.

I give my permission for New Castle County and/or the Summer Recreation Camp Staff to release and receive protected health information regarding my child in the event that the information is required for the completion of medical records and referrals made, but not limited to, consultants, labs, and hospitals involved in my child's care.

Parent / Guardian Name	Parent / Guardian Signature	Date

No child will be allowed in camp without a completed current medical form. The medical form will be kept at camp so it is important that all information is provided as accurately as possible to ensure the Camp Administration can easily access information as quickly as possible. For example: emergency contact information.

Authorization to take Medication: The State of Delaware requires proper documentation for prescription medication to be given at camp. If your child will be attending camp with an epi-pen, nebulizer, or any other prescribed medication, this form must be filled out and submitted with medication in original container.
All campers must have their completed packet submitted to the Summer Camp Office prior to the start of their camp session. It is important for us to understand your child's medical and behavioral needs. We want our staff as prepared as possible to ensure your child's safety and to provide the best possible camp experience. The State of Delaware requires this form be completed each year.

Authorization for Medication to Be Taken During Camp Hours

THIS FORM ONLY NEEDS TO BE FILLED OUT IF CAMPER WILL BE TAKING MEDICATION AT CAMP.

The following section is to be completed by the **PARENT**:

CAMPER:	LAST NAME	FIRST NAME	SEX	DATE OF BIRTH

Physician's Name:	Phone:

Physician's Address:

I request that my child be assisted by authorized persons in taking the medication(s) described below while at camp or permitted to medicate herself/himself as authorized by my physician and me. (See below.) ☐**YES** ☐**NO**

Signature of Parent/Guardian:	Date:

Home Phone	Emergency Phone

*THE FOLLOWING SECTION IS TO BE COMPLETED BY THE **PHYSICIAN**:*

NAME OF MEDICATION:

DOSAGE:

If medication is to be taken DAILY, at what time?

If medication is to be given "WHEN NEEDED," describe indications:

How soon can dose be repeated?

Is camper authorized to medicate herself/himself?

List significant side effects:

PHYSICIAN'S SIGNATURE:	DATE:

MEDICATION (Prescription and over-the-counter)
All medications must be in their original container with the information clearly labeled on the container. All medication must be prescribed in writing by the physician either on the health form or dated prescription order. This must include dosage and schedule. If this is a prescription drug, the doctors' orders must be the same as on the label of medication container. We can only follow the physician's written order. An authorization for medication form must accompany the medication. **All medication (prescription or over-the-counter) must be handed to the Head Counselor or Camp Coordinator at the sign-in table.**