

CAMP WEEK DATES: _____
 DEAN _____

TRI-STATE CHRISTIAN SERVICE CAMP HEALTH FORM

Camper/Jr. Staffer's Name _____	Age/DOB _____ / _____
Parent/Guardian Name _____	Phone # _____
Second Contact Name _____	Phone # _____
ALLERGIES _____	Last Tetanus Shot _____
Date/Type of recent illness/surgery _____	Weight _____

By signing below, I give my permission for the medications listed on this form to be given by the Tri-State Christian Service Camp Staff. Also, I give permission for the Camp Manager, Dean, or Medical Staff of Tri-State Christian Service Camp to provide any emergency treatment and transfer to the nearest medical facility for treatment, should the need arise. I hereby release and hold harmless Tri-State Christian Service Camp, its faculty and directors of any and all liability, with the exception of that which is covered by the camper's insurance. Also, I know that I am responsible for obtaining any unused portion of my child's medications prior to taking my child home from camp.

Signature _____ Date _____

Fill in below if your child will or may need prescription medications while at camp.

PRESCRIPTION MEDICATIONS CHILD CURRENTLY TAKING

SECTION BELOW FOR CAMP STAFF USE ONLY

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday

Medical Staff Initials/Signature _____
 Medical Staff Initials/Signature _____

**ALL MEDICINE MUST BE TURNED IN TO MEDICAL STAFF AT REGISTRATION!
 POSITIVELY NO MEDICATIONS IN CABINS!!!**

TRI-STATE CHRISTIAN SERVICE CAMP HEALTH FORM

At times it is useful to administer over the counter medications for minor injuries and illness while your child is at camp. Below is a list of over the counter medications we have available for use. Please place an X in the box next to the medications you approve of us giving your child. The dosage you give your child would be helpful as well. If no dosage is given we will follow the instructions on the label. Please be assured that for anything other than minor illnesses or injuries you will be called.

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DEAN _____

AS NEEDED MEDICATION DOSAGE	X in box indicates approval to give medication. Circle type (Liquid, Chewable, etc.)						
	X/TYPE	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday
Antibiotic Ointment							
Anti-Itch Cream							
Benadryl							
Betadine							
Cough Drops							
Cough Syrup							
Ear Drops							
Eye Drops							
Ibuprofen(Advil/Motrin)	chewable						
	liquid						
	tablet						
Pepto-Bismol	chewable						
	liquid						
Peroxide and/or Alcohol							
Sunburn Cream							
Sunscreen							
Tylenol(Acetaminophen)	chewable						
	liquid						
	tablet						

Parent/Guardian Signature _____

Medical Staff Initials/Signature _____

Medical Staff Initials/Signature _____

Medical Staff please be sure to document why each as needed medication was given and the result of it being given on the provided sheet entitled Medical Staff Notes. Please staple each note sheet to this child's form.