Christmount

222 Fern Way, Black Mountain, NC 28711
info@christmount.org • (828) 669-8977 • Fax (828) 669-6301

Week Assigned ________

Camp Lakey Gap: Camper Medical Form

In order for your camper to remain at camp you must:

1. Have form **REVIEWED AND SIGNED** by camper's attending medical professional
2. Prescription and over-the-counter medications must be in their **ORIGINAL CONTAINERS**
3. Prescription and over-the-counter medication's **CONTAINERS MUST MATCH WHAT IS ON FORM**
4. Please **DON'T SEND THE EXACT NUMBER OF PILLS** needed for the week; it is helpful to send a few extras.

Camper Information

Full Name____Preferred Name________________________________

Date of Birth ____/____/____ Age ____ Sex ___ Height _____ Weight _____SSN # _____-_____-______

Parent or Guardian____

Address____

City ____ State _____________ Zip ___________________________

Mother - Home (____)______________ Work (____)________________ Cell/Pager (____)______________

Father - Home (____)______________ Work (____)________________ Cell/Pager (____)______________

Phone # during camp (completed by nurse at registration)____

Emergency Contacts (different than above)

Name _________________________ Phone (_____) ____________________Relationship________________

Name _________________________ Phone (_____)_____________________ Relationship________________

Residential Facility

Facility Name ____

Name of Staff Contact ____

Address ____

City ____ State _____________ Zip ___________________________

Telephone (____)____________________ Emergency Phone Number (____)____________________________

Dentist

Name of Dentist ____ Phone (______) ______________________

Health and Accident Insurance

Company Name ____

Policy Holder _____________________________________ Policy Number ______________________________

Health History

Any of the following that are checked YES, provide dates and health care provider comments

History of	Yes	No	Dates and health care provider comments
Ear Infections			
Heart Defect/Disease			
Seizures (date of most recent)			
Diabetes			
Asthma			
Hypertension			
Bleeding/Clotting Disorders			
Chicken Pox			
Mononucleosis			
Poison Ivy Reaction			
Hay Fever			
Insect Stings			
Penicillin			
Date of most recent tetanus shot			
Other Allergies			
Other (describe)			

Prescription Medications

These medications are current as of ____/____/____

Name of Drug: ______________________ Indication for Use: ____________________ Dosage/Frequency: ___________________ How Administered: ____________________ Dr. Prescribing/phone #:________________	Name of Drug: ______________________ Indication for Use: ____________________ Dosage/Frequency: ___________________ How Administered: ____________________ Dr. Prescribing/phone #:________________
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Attach additional pages as needed

Have there been any recent changes in the dosages and/or procedures for any of the listed medications? Explain

____

____

Are there any side effects associated with these medications that will be of concern at camp? (i.e., sun sensitivity)

____

____

Over the counter medications, vitamins, and topicals

Over the counter medications must be on this list if they are to be administered at camp

Name of Drug: ____________________ Indication for Use: ____________________ Dosage/Frequency: ____________________ How Administered: ____________________	Name of Drug: ____________________ Indication for Use: ____________________ Dosage/Frequency: ____________________ How Administered: ____________________
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All medications (prescription and over-the-counter) must be sent in the ORIGINAL CONTAINER

DO NOT:
mix pills in one container
bring pills in an unlabeled container
put pills into a week organizer

Camp-provided over-the-counter and topical medications

I give consent for ____________________ to receive the following over the counter medications:
Parent / Guardian Signature: ____________________ Date: ____________
The medications will be given according to the package directions unless indicated differently below.

	Children's Acetaminophen (ex. Children's Tylenol)	
	Acetaminophen (ex. Tylenol)	
	Children's Ibuprofen (ex. Children's Advil, Children's Motrin)	
	Ibuprofen (ex. Advil, Motrin)	
	Children's Diphenhydramine Hydrochloride (ex. Children's Benadryl)	
	Diphenhydramine Hydrochloride (ex. Antihistamine, Benadryl)	
	Loperamide (ex. Pepto Bismal, Imodium) *not for children under 12 years of age*	
	First Aid Antibiotic Ointment (ex. Neosporin)	
	Diphenhydramine Cream and Gel (ex.Benadryl cream or gel)	
	Aloe Vera Gel	
	Alcohol Ear Drops (ex. Swim Ear)	

Medical Certification

I have examined ______________________, and certify that there is no medical evidence which would prevent this camper from participating in Camp Lakey Gap's activities during the summer of 2012.

Attending Medical Professional's Signature______________________________________ Date_________
Attending Medical Professional's Name (PRINT)____
Address:____ City ____________________________
State ______ Zip ____________ Phone (_____)______________ Fax (_____)______________________
Email ____

Please list a second medical contact for information if physician listed above is not reachable by phone.
Name ____
Emergency Phone (_____)__________________
Address ____________________________________ City _________________ State ____ Zip________

Note to the attending medical professional: We will need written notice from you of any changes (health and prescription) in the information contained on this form.

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4. Please **DON'T SEND THE EXACT NUMBER OF PILLS** needed for the week; it is helpful to send a few extras.

Return this form at least two weeks before your camper's week to:

Christmount Assembly
Camp Lakey Gap
222 Fern Way
Black Mountain, NC
28711
fax: 828-669-6301

In order to shorten the time it takes to get all of our camper's medications checked in, please fill this out and send it with your medical form. If your camper takes a medication that does not fall during one of our meal times, please note the specific time that it needs to be given. Also, be sure to include both the amount and the dosage of the medicine.

If there are any changes to medications, amounts, or dosages, please have the prescribing doctor fax us the new prescription so that we can make that change.

Time	**Medication**	**Amount and Dose (ex. 1 tablet, .25 mg)**
AM (Before Breakfast) **Time:**		
Breakfast **8:30**		
Morning **Time:**		
Lunch **12:00**		
Afternoon **Time:**		
Dinner **5:30**		
Evening **Time:**		
Bed **8:00**		