



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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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 #: _____

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.

<input type="checkbox"/>	Children's Acetaminophen (ex. Children's Tylenol)	
<input type="checkbox"/>	Acetaminophen (ex. Tylenol)	
<input type="checkbox"/>	Children's Ibuprofen (ex. Children's Advil, Children's Motrin)	
<input type="checkbox"/>	Ibuprofen (ex. Advil, Motrin)	
<input type="checkbox"/>	Children's Diphenhydramine Hydrochloride (ex. Children's Benadryl)	
<input type="checkbox"/>	Diphenhydramine Hydrochloride (ex. Antihistamine, Benadryl)	
<input type="checkbox"/>	Loperamide (ex. Pepto Bismal, Imodium)	
<input type="checkbox"/>	First Aid Antibiotic Ointment (ex. Neosporin)	
<input type="checkbox"/>	Diphenhydramine Cream and Gel (Benadryl cream or gel)	
<input type="checkbox"/>	Aloe Vera Gel	
<input type="checkbox"/>	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 2010.

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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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
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