

# All God's Children Camp

## Health Screening Information

To help us provide the best medical care possible for your camper while at the All God's Children Camp, please fill out the information below and **please have your camper bring it with him/her when coming to camp.**

Camper's Name \_\_\_\_\_ Birthday \_\_\_\_\_ Age \_\_\_\_\_ Camp \_\_\_\_\_

1. Recent surgery, injuries, or illnesses that the staff should be aware of:

2. Is your camper on any prescription medicine? Yes or No

If yes, **PLEASE INCLUDE DOSES, TIMES, AND SPECIAL INSTRUCTIONS.** We require that children taking prescription medication remain on this medication during the week of camp. Medicine **MUST** be with the camper and turned into camp staff on Sunday. (Use back of page for explanation if needed)

3. Is your camper current on his/her immunizations? Yes or No

Date of last tetanus shot:

4. Is there any other health information we should know about, including (check all that apply and list any that aren't mentioned)?

\_\_\_\_\_ Camper wears contact lenses

\_\_\_\_\_ Camper suffers from ADD or ADHD

\_\_\_\_\_ Camper has allergies (other than seasonal allergies)- please list:

\_\_\_\_\_ Diet Modifications (please explain)

\_\_\_\_\_ Other concerns:

5. In case of headaches, low grade fever (under 100), slight stomach upset, mild diarrhea or allergic reactions to bee stings or poison ivy, oak or sumac, the camp has my permission to administer the following:

\_\_\_\_\_ Tylenol

\_\_\_\_\_ Ibuprofen

\_\_\_\_\_ Benadryl

\_\_\_\_\_ Tums Antacid

\_\_\_\_\_ Sudafed

\_\_\_\_\_ cold/cough medicine

\_\_\_\_\_ Imodium AD

\_\_\_\_\_ Other

5. Authorization for treatment: I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests or treatment for the child named above as needed. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the child named above.

\_\_\_\_\_  
Signature of Caregiver

\_\_\_\_\_  
Date

\_\_\_\_\_  
Caregiver Name (Printed)

(\_\_\_\_\_)\_\_\_\_\_  
Best Contact Phone Number