

COVENANT ACRES CAMP

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INSURANCE AND HEALTH FORM			
Child's Name	Legal Guardian	Relationship	
Phone: Home	Work (and ext.)	Pager	Cell
Alternate Emergency Contact Person		Relationship	
Phone: Home	Work (& ext.)	Pager	Cell
Address:	City	State	Zip Code
Health Insurance Carrier	Policy Number	Name of Policy Holder	
Company through which policy is held:			
Primary Care Physician:		Telephone (area code and) Number	
<p>New State Law requires that the camp maintain an up-to-date record of your child's immunizations (month and year of last booster). New campers MUST fill this out.</p> <p>Haemophilus influenza type b ___ / ___ / ___</p> <p>Varicella ___ / ___ / ___ Hepatitis b ___ / ___ / ___</p> <p>Diphtheria ___ / ___ / ___ Mumps ___ / ___ / ___</p> <p>Oral Polio ___ / ___ / ___ Measles ___ / ___ / ___</p> <p>Tetanus ___ / ___ / ___ Rubella ___ / ___ / ___</p> <p>Check if camper has had any of the following:</p> <p>___ Chicken Pox ___ Frequent colds ___ Mumps</p> <p>___ Red Measles ___ Hay Fever ___ Hepatitis</p> <p>___ German Measles ___ Appendicitis ___ Bedwetting</p> <p>___ Tonsillitis ___ Toothaches ___ Asthma</p> <p>___ Whooping Cough ___ Rheumatic Fever ___ Sinusitis</p> <p>___ Ear Trouble ___ Stomach Aches</p> <p>___ Epilepsy or Fainting</p> <p><small>By signing below, you certify that to the best of your knowledge, your child is in good health and that you agree to notify the camp if your child is exposed to an infectious disease during the three weeks prior to camp.</small></p>		<p>Medications presently taken: <input type="checkbox"/> None</p> <p><input type="checkbox"/> See Primary Care Physician's report</p> <p>Health / Activity Restrictions: _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Describe injections or treatments required:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Allergies to medications: _____</p> <p>_____</p> <p>_____</p> <p>_____</p>	

Signature of Parent or Legal Guardian

Date

Dear Parent,

To keep current with the many different state codes regarding dispensing medication to campers, we are required to have a doctor's signed form before our nurse can dispense over the counter medications or current prescription medications to your child. Please fill out this form and have it signed by your doctor or current healthcare provider. **Without this completed form on file, we cannot dispense any form of medication to your child!**

Individualized Orders for: Camper _____

Date of Birth ___/___/___ Height _____ Weight _____

Standard over the counter medications/PRN Medications (The following medications are available in the infirmary and will be administered at the discretion of the medical staff, only if the camper's healthcare provider indicates approval.)

Medication	Administer order	Routine	Dose/Time
Tylenol	Yes No	PO	
Ibuprofen	Yes No	PO	
Advil	Yes No	PO	
Tums	Yes No	PO	
Pepto Bismol	Yes No	PO	
Kaopectate	Yes No	PO	
Benadryl	Yes No	PO	
Mylanta Liquid	Yes No	PO	
Neosporin	Yes No	PO	

Prescription Medications: Please complete this table with your camper's current regimen for both over the counter and prescription medications, including inhalers. All medications sent to the camp must be in their original containers. No pill boxes or unlabeled containers will be accepted. (Use additional paper if necessary.)

Medication	Route	Dosage	Time(s)	Diagnosis

For EpiPen & Inhalers: Has camper been trained in proper use of inhaler or EpiPen? YES NO

Parental consent for child to keep EpiPen or inhaler? Y / N _____
Signature of parent or legal guardian

Name of Camper's Healthcare Provider: _____

Address of Provider: _____

Provider's License # _____ Phone: (_____) _____

Provider's Signature: _____ Date: _____