

YMCA CAMP JONES GULCH

2012 Medication Authorization & Health Examination

FORM C

Camper Name _____ Session _____ Cabin (For Camp Use Only) _____

I, (parent/guardian) _____, the parent or guardian of the above listed camper, hereby, request that the YMCA Staff administer the following prescription and/or over-the-counter medication(s) to my child.

Medication is generally administered at breakfast, lunch, dinner, and before bed. Indicate which time applies and note if another specific time is necessary. Attach another sheet if your child takes more medication.

	Medication	Dosage	Daily/As Needed	Time of Day	Special Notes
1.					
2.					
3.					
4.					

Please give a description and symptoms of the condition that requires the child to take medication. _____

Possible adverse reactions which staff should be aware of include _____

How is your child's attitude about taking medication (e.g. cooperative, resistant, embarrassed, etc.)? _____

Other special instructions: _____

****Medications must be in their original containers, labeled, and match the camper's name!****

****Prescriptions must be for the camper only, not anyone else.****

Signature of Parent/Guardian _____

Date Signed ____/____/____

REQUIRED: Health Examination By Licensed Physician

ALL CAMPERS ARE REQUIRED TO HAVE WRITTEN CONFIRMATION OF A HEALTH EXAMINATION WITHIN 24 MONTHS OF ATTENDING YMCA CAMP JONES GULCH. Camp is held in an outdoor setting, with programs that are very active, including hiking, games, swimming, and traditional camp activities. Your careful consideration is appreciated.

I have examined the child named on this form within the past two years. Yes No Date Examined ____/____/____

Is the applicant under the care of a physician for any conditions? Yes No If yes, please explain: _____

Any specific activities to be encouraged or limited by physician's advice? _____

Any treatment or medications to be continued at camp (please give specific dosages)? _____

Additional health information: _____

After examination and my review of his/her health history, it is my opinion that this person is physically able to engage in camp activities, except as noted above.

Licensed Physician (sign and print name): _____ Date: ____/____/____

Address: _____ Phone: (____) _____

Form completed by: _____ Date: ____/____/____

Camper Name: Last _____

First _____

Session: _____

Cabin: _____

(for office use)