

Camp Koinonia 2007 Physician Form of Medication Administration

This form is good for up to one year only.

The following is to be completed by a health care provider (physician/nurse practitioner). No medication of any kind will be given to your child until this information is completed and returned.

- All medication must be in a **pharmacy-labeled** container.
- If any changes in medication occur before camp, a new form must be completed along with a new pharmacy/physician labeled container.
- A parent/guardian signature is required before a camper can be assisted with self medication.

TO BE COMPLETED BY THE PARENT/GUARDIAN:

Child's name _____ Date of Birth ___/___/___

I hereby give consent for my child to be assisted in taking the medication described below at camp. I also authorize, as needed, the sharing of information related to my child's health between the camp nurse (or designee) and the health care provider listed below.

Parent/Guardian Signature

Parent/Guardian Name (PLEASE PRINT)

(_____) _____
Home Phone

(_____) _____
Work Phone

Emergency Contact (Name, Phone, and Relation to Camper)

_____/_____/_____
Date

THE FOLLOWING FORM IS TO BE COMPLETED BY HEALTH CARE PROVIDER ONLY:

Physician/Nurse Practitioner's Name (PRINT) _____

Physician/Nurse Practitioner's Signature _____ Date ___/___/___

Address _____ City _____

State _____ Zip Code _____ Phone (_____) _____

Fax _____

Camp Koinonia 2007
Medical Form
(To be completed and signed by a physician)

Camper's Name _____ Age _____ Birth date _____

Height _____ Weight (lbs.) _____ Temperature _____

Blood Pressure _____ Heart Rate _____ Respirations _____

Lab: Urinalysis-Albumin _____ Sugar _____

Within Normal Limits?

Comments:

Vision	() YES () NO	_____
Hearing	() YES () NO	_____
Growth development	() YES () NO	_____
Skin	() YES () NO	_____
Ears	() YES () NO	_____
Thyroid, head, neck	() YES () NO	_____
Nose	() YES () NO	_____
Teeth	() YES () NO	_____
Tonsils	() YES () NO	_____
Musculoskeletal	() YES () NO	_____
Genitalia	() YES () NO	_____

Allergies:

Food: _____ Environmental: _____

Are all immunizations current? () YES () NO

Has your child received a tetanus shot within the last 10 years? () YES () NO
 (If not, he/she must have one at least two weeks prior to camp)

Date of last tetanus shot: _____

Restrictions: () NONE

Diet: _____ Activity: _____

Please indicate if the individual has experienced the following:

- Chicken Pox
- Convulsions
- Diabetes
- Diphtheria
- DPT (immunization)
- Ear Infection(s)
- Headaches
- Heart Disease
- Hemophilia

- High Blood Pressure
- HIV/AIDS
- Measles
- Mumps
- Polio Series
- Pneumonia
- Scarlet Fever
- Tuberculosis
- Whooping Cough

Explanation(s) _____

Has the child received the series of Hepatitis immunizations? () YES () NO

Does the child take any prescribed medications? () YES () NO

If YES, please document medications below, if necessary please attach a separate piece of paper.

Please list ALL medications the child takes. Please send an ample supply of all medications to camp, in **ORIGINAL MEDICATION CONTAINERS** - the child's name, physician name, pharmacy name, and appropriate administration instructions on the container. WE MUST HAVE MEDICAL INFORMATION PRIOR TO CAMP. Please Print.

Child's Name _____

	Medication Name	Dosage	Specific Times of Administration	Purpose of Medication
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Physician Signature _____

Date _____