Florida College Dry Creek Camp

# Change Medical Form

**Do Not Mail!**
**Bring To Camp!**

1. **If you answer "Yes" to *any* of these questions, complete this form and bring to Camp.**
2. **If you answer "No" to *all* questions, disregard this form.**

- Is there a change in health status that was not changed on Online Medical Form? Yes or No
- Is there a change in medication that was not changed on Online Medical Form? Yes or No
- Is there a change in insurance that was not changed on the Online Medical Form? Yes or No
- Is there a change in a contact number that was not changed on Online Medical Form? Yes or No
- Has there been an exposure to a communicable disease in the past 2 weeks? Yes or No

Name _____ DOB _____ Age at Camp _____
Last First Middle

Address _____
Street City State Zip

Camper's SS# _____ - _____ - _____ (for medical purposes) Camper's Sex: Male ____ Female ____

Parent/Guardian's Name: _____ SS# _____ - _____ - _____

Address _____
(If different from above) Street City State Zip

How to reach Parent/Guardian during camp? Mom's Phone (_____)_____Dad's Phone (_____)_____

**Name of an emergency contact who may be contacted in case you cannot be reached:**

Name _____ Relationship: _____ Phone: (_____)_____

## INSURANCE:

Is this camper covered by family medical/hospital insurance? No ___ Yes ___ **If yes, attach copy of insurance card (front/back).**

Insurance Company name _____ Policy # _____

Policy Owner_____ Insurance Company Phone (_____)_____

## GENERAL HEALTH AND MEDICAL HISTORY:

1. Specify any chronic or long-term illness: _____
2. Specify any operations or serious injuries: _____
3. Had these diseases? Measles __ German Measles __ Mumps __ Chicken Pox __ Other: _____
4. **Allergies?**: Drugs _____Food _____
   Animals _____ Plants _____ Other _____
   Explain reaction and indicate medication used. _____
5. Check any of the following: Sleepwalking ___ Other sleep disturbances ___ Nightmares ___ Fainting ___ Asthma ___ Seizures ___
   Stomach upsets ___ Constipation ___ Emotional/Family problems ___ Phobias ___ Attention Deficit _____ Give details: _____
   _____
6. Immunizations Up-To-Date? DPT ___ MMR ___ Polio ___ Chicken Pox ___ Other _____
7. **Restrictions**: Any activity restrictions? No ___ Yes ___ If yes, specify: _____

**MEDICATION:** Is he/she bringing medication to camp? No ___ Yes ___ **If yes, complete Medication Schedule, page 2.**

## BE SURE TO SIGN BELOW:

This health history is correct and complete. Unless otherwise stated and noted in this document, the person named in this application has permission to engage in all Camp activities. I hereby give permission to the Camp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for my child, as necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I agree to release any records necessary for treatment, referral, billing, or insurance purposes. Further, I understand that this Medical Form will go with my child to any medical facility and be available to all attending personnel.

Date _____ Signed _____ Parent ___ Legal Guardian ___ (Check one)

Printed Name _____

Camper's Full Name: _____

# Medication Schedule

**All medications must be in original container with pharmacy label. Please do not bring common over the counter meds. We have those in stock.**

| #1 Self-Given? (Circle One) | #2 Mandatory? (Circle One) | #3 Name of Medication or Treatment | #4 Name of Condition | #5 Dosage | #6 Frequency of med. or treatment (Circle One) | #7 Times (Circle all that apply) | #8 If "As Needed", how are we to decide? |
|---|---|---|---|---|---|---|---|
| Yes / No | Yes / No | | | | 1/day 2/day 3/day 4/day As Needed | B L S BT | |
| Yes / No | Yes / No | | | | 1/day 2/day 3/day 4/day As Needed | B L S BT | |
| Yes / No | Yes / No | | | | 1/day 2/day 3/day 4/day As Needed | B L S BT | |
| Yes / No | Yes / No | | | | 1/day 2/day 3/day 4/day As Needed | B L S BT | |
| Yes / No | Yes / No | | | | 1/day 2/day 3/day 4/day As Needed | B L S BT | |

#1 Self-Given:
- If yes, camper will keep the medication and be responsible for taking it; staff will not monitor administration of the meds. This will generally apply to older campers and/or over the counter medications.
- If no, nurse will keep medication and will monitor its administration.

#2 Mandatory:
- If yes, all dosages must be taken on schedule.
- If no, this medication will only be taken as needed (as a symptom presents itself). If taken only "as needed", please explain in column 8.

#3 Name of Medication or Treatment: Medication as named on prescription bottle or package.
#4 Condition: Condition for which this medication is given.
#5 Dosage: Strength of each dose as indicated on prescription (ex. 250 mg.)
#6 Frequency: The number of doses or treatments per day.
#7 Times: The time of day the camper will take the medication. (B= Breakfast; L= Lunch; S= Supper; BT= Bedtime)
#8 As Needed (or Not Daily): Explain whether the nurse or the camper determines the need and how they are to determine the need. Also, explain when to initiate or discontinue treatment. For "Not Daily" explain, (ex. Monday only, etc.).

**Notes for the Nurse** (Additional comments can go here and/or on a separate sheet. **Write Camper's Full Name on any additional pages.**)**:**