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 the Online Medical Form? Yes or No
   - Is there a change in medication that was not changed on the 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 the Online Medical Form? Yes or No
   - Has there been an exposure to a communicable disease in the past 48 hours? 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.

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

#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 Times: The time of day the camper will take the medication. (B= Breakfast; L= Lunch; S= Supper; BT= Bedtime)
#7 Frequency: The number of doses or treatments per day.
#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.**)**:**