Health Form
Due: August 26, 2022

Student's Name_____ Home phone number: _____
Mother's name:_____Employer:_____
Mother's work phone:_____Mother's cell phone number:_____
Father's name:_____Employer:_____
Father's work phone: _____Father's cell phone number: _____
In the event the parent cannot be reached another emergency number.
Name _____ Phone Number _____ Relationship_____
Name of physician: _____Office Phone _____

1. Does your child have any allergy, which might affect him/her in a camping experience (Poison Ivy, Poison oak, pollen, trees grass, food, bees, other?) Yes ___ No ___ If yes, give details _____
   _____
2. Do you know of any health factor that makes it advisable for you child to follow a limited program of physical activity? Yes ____ No _____ If yes, please explain:
   _____
3. What is the date of you child's last tetanus shot? _____
4. Has your child stayed away from home before? Yes ____ No _____
5. Does your child sleepwalk? Yes ____ No _____
6. Does your child have any other bedtime habits we should be aware of? Yes ____ No _____ If yes, please explain: _____
7. Please specify any other information that might be helpful to the staff in caring for you child: _____
8. Is your child able to take regular strength non-aspirin? Yes ____ No _____ If yes, does the nurse or a staff member have your permission to give non-aspirin for minor complaints? Yes ____ No _____ His/her usual dosage is: _____
9. Can your child swallow pills? Yes ____ No _____ If no, please send chewable pills to camp.

SIGNATURE OF PARENT/GUARDIAN_____

If your child takes prescription medications, they must be sent to school in the original bottle from the pharmacy. The medications will be given to the nurse the first day of camp. Use the backside of this paper to list the medications taken, the time, and the dosage.

If you would like to give specific information, please call the school nurse, 849-1102 Ext. 3102 from the hours of 12:00-3:30 during the school week.

Prescription Medication

Name of student_____

Name of medication_____
Dosage_____
Time to administer_____

Name of medication_____
Dosage_____
Time to administer_____

Name of medication_____
Dosage_____
Time to administer_____

If more room is needed, please start a new column on this paper.
Parent's signature if prescription medication is to be administered.

_____