CAMP KROC Medical Form

Ray & Joan KROC Corps Community Center Grand Rapids, MI

Please complete one form in full per child.

CAMPER NAME ____ ○ MALE ○ FEMALE

PARENT/GUARDIAN NAME ____ PHONE ____ ○ CELL ○ HOME

EMAIL (REQUIRED) ____

CHILD'S HEALTH HISTORY & INFORMATION

The information provided will assist our staff in providing the best care for your child.

CHECK IF APPLICABLE

- ☐ BLEEDING/CLOTTING DISORDER
- ☐ MONONUCLEOSIS
- ☐ CONVULSIONS/EPILEPSY
- ☐ DIABETES
- ☐ HEART DEFECT/DISEASE
- ☐ BEHAVIORAL CHALLENGES
- ☐ HYPERTENSION
- ☐ ASTHMA -CARRIES MEDICATION ☐ YES ☐ NO
- ☐ FREQUENT EAR INFECTIONS

ALLERGIES

- ☐ INSECT STING/BITES
- ☐ POISION IVY/OAK
- ☐ HAYFEVER
- ☐ SUNSCREEN
- ☐ INSECT REPELLENT
- ☐ OTHER:
- ☐ CARRIES EPIPEN

CONDITION	MILD	MODERATE	SEVERE
ASPERGERS	☐	☐	☐
AUTISM	☐	☐	☐
ADD/ADHD	☐	☐	☐
LEGALLY BLIND	☐	☐	☐
DEAF/HEARING IMPAIRMENT	☐	☐	☐
OTHER	☐	☐	☐

Might your child **require special attention or assistance** to participate in daily camp activities?

○ YES ○ NO ○ NOT SURE

PLEASE NOTE YOUR CHILD'S RESTRICTION(S), INCLUDING FOOD ALLERGIES:

☐ VEGETARIAN ☐ VEGAN ☐ KOSHER ☐ PEANUT FREE ☐ LACTOSE FREE ☐ GLUTEN FREE ☐ OTHER:

Please note any physical limitations, recent operations, serious injuries, diseases:

Please list any known allergies to drugs of any kind (prescription or over-the-counter):

Please list any medications your child takes and its purpose (separate medication form also required):

Please note any additional information that may affect your child's experience at camp (recent move, family trauma, etc.):

INSURANCE & IMMUNIZATION INFORMATION: REQUIRED BY STATE LAW

INSURANCE COMPANY ____ POLICY NUMBER ____

FAMILY/PRIMARY PHYSICIAN ____ PHONE ____

ARE YOUR CHILD'S IMMUNIZATIONS UP TO DATE*? ○ YES ○ NO DATE OF LAST TETANUS SHOT: ____

*SIGNATURE REQUIRED FOR THOSE WHO CHOOSE NOT TO VACCINATE/IMMUNIZE: ____

CAMP KROC Medication Form

RAY & JOAN KROC CORPS COMMUNITY CENTER GRAND RAPIDS, MI

- **All prescription and non-prescription medications brought to Camp Kroc must be accompanied by this completed form.**
- **Medication must be in its original packaging with prescription label.**
- **Medications are to be dropped off and picked up each day by a parent or authorized adult, unless other arrangements have been made with the Day Camp Supervisor.**
- **Medications are kept in secure storage and administered by camp staff only.**

CHILD'S NAME _____ DATE OF BIRTH _____

CAMP DATE(S) _____

MEDICATION #1

○ ONGOING ○ TEMPORARY - DATES: _____

MEDICATION & STRENGTH _____ DOSE _____

DATE PRESCRIBED _____ EXP DATE _____ QTY PRESCRIBED _____ QTY SENT TO CAMP _____

ADMINISTRATION INSTRUCTIONS _____

STORAGE INSTRUCTIONS _____

REASON FOR MEDICATION _____

POSSIBLE SIDE EFFECTS _____

WHICH, IF ANY, OF THESE SIDE EFFECTS HAS YOUR CHILD EXPERIENCED? _____

WHAT ARE THE EXPECTED CONSEQUENCES IF MEDICATION IS NOT TAKEN AS DIRECTED? _____

MEDICATION #2

○ ONGOING ○ TEMPORARY - DATES: _____

MEDICATION & STRENGTH _____ DOSE _____

DATE PRESCRIBED _____ EXP DATE _____ QTY PRESCRIBED _____ QTY SENT TO CAMP _____

ADMINISTRATION INSTRUCTIONS _____

STORAGE INSTRUCTIONS _____

REASON FOR MEDICATION _____

POSSIBLE SIDE EFFECTS _____

WHICH, IF ANY, OF THESE SIDE EFFECTS HAS YOUR CHILD EXPERIENCED? _____

WHAT ARE THE EXPECTED CONSEQUENCES IF MEDICATION IS NOT TAKEN AS DIRECTED? _____

PERMISSION TO CARRY & SELF-ADMINISTER

Parents may authorize campers to carry and self-administer their medications (such as EpiPens for anaphylactic reactions or asthma inhalers) as needed for life-threatening conditions. Prior written approval is needed for campers to carry any other medication.

PARENT/GUARDIAN SIGNATURE _____ DATE _____

By signing this form, I acknowledge that my child has been instructed on the purpose, administration, and other necessary information regarding this medication and authorize him or her to self-administer as needed.

CAMPER SIGNATURE _____ DATE _____

By signing this form, I acknowledge that I understand the purpose, administration, and other necessary information regarding this medication and will self-administer as needed.