Shiloh Park

Children's Summer Camps 2018

Camper Medical Form

Child's Full Name ____ **Birthdate** _____/_____/________

I give my permission for the above named child to participate in all camp activities including but not limited to climbing, swimming, kayaking, and water sliding. I hereby authorize the staff and volunteers of Shiloh Park camp and NEI, NWI, INDY children's camp to administer basic medical first aid and emergency medical or dental treatment if needed and to seek medical treatment from a hospital or doctor. I give permission for the camp nurse to administer medications as directed (**medications listed on reverse side of this form**). I give permission for my child to be photographed or videotaped for camp promotional materials or social media.

I give permission for my child to be given: ___ Tylenol ___ Ibuprofen ___ Benadryl

Parent or Guardian (printed name) ____ Date__________________________

Signature of parent or guardian___________________________-____

Address____City, State, Zip___________________________________

Parent /Guardian phone number(s)____

Secondary Emergency Contacts

Name:________________________________Relationship to child___________________Phone____________________

Name:________________________________Relationship to child___________________Phone____________________

Family Doctor ____ Phone_____________________

Medical Insurance Carrier____________________________________ ID #______________________________________

Name of Insured ____

Camper Personal Information

Date of Last Tetanus Shot _____/_____/_____ Allergies and medical conditions___________________________________

____

Is there anything else that we should know about your child to best care for him/her?________________________________

____

****** NEW! Lice checks will NOT be offered upon arrival! This MUST be completed PRIOR to coming to camp!******

Head Lice Inspection (must be completed by a licensed medical professional or cosmetologist)

"I certify that the child named above shows no evidence of lice, nits, or eggs."

Signed____

Credentials/Title____ Date _____/_____/_____

To be completed by camp staff: ________Passed Temp. Check

Child's Name____Age___________Weight________________

This box to be completed by camp staff:

Cabin________________CounselorName____________________________Phone__________________

Nurse Initials_____ Printed Name_______________________Signature__________________________

Parent Please Complete:		To be completed by the nurse							
Medication	Check when to be given	Day 1 Date:		Day 2 Date:		Day 3 Date:		Day 4 Date:	
		Clock	Init	Clock	Init	Clock	Init	Clock	Init
Dosage	Breakfast								
	Lunch								
Reason / Special Instructions	Dinner								
	Bedtime								
	As Needed								
Medication	Check when to be given	Day 1		Day 2		Day 3		Day 4	
		Clock	Init	Clock	Init	Clock	Init	Clock	Init
Dosage	Breakfast								
	Lunch								
Reason / Special Instructions	Dinner								
	Bedtime								
	As Needed								
Medication	Check when to be given	Day 1		Day 2		Day 3		Day 4	
		Clock	Init	Clock	Init	Clock	Init	Clock	Init
Dosage	Breakfast								
	Lunch								
Reason / Special Instructions	Dinner								
	Bedtime								
	As Needed								
Medication	Check when to be given	Day 1		Day 2		Day 3		Day 4	
		Clock	Init	Clock	Init	Clock	Init	Clock	Init
Dosage	Breakfast								
	Lunch								
Reason / Special Instructions	Dinner								
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	As Needed								