BROWARD JUNIOR ACADEMY SUMMER DAY CAMP

HEALTH SERVICES FORM / EMERGENCY CONSENT

PERSONAL AND CONFIDENTIAL

In order for our staff to properly care for your child, we ask that this form be completed on both sides and returned no later than: **May 1, 2017**

◆NOTE – Without signature – Off-Campus activities will be restricted ◆

Science ___Theatre___ Soccer____ Tennis____ Young Artist_____ Robotics____Video Production ____

Camper Name____D.O.B.____________PIN______________
Last *First*

Address____ Weight______ Height________
Street *City* *ST* *Zip Code*

In case of emergency, the staff will call these numbers in the order listed:

Mother's Name________________________________Home Phone____________________Cell______________________

Father's Name________________________________ Home Phone____________________Cell______________________

Other_______________________________Home/Cell______________________Relationship______________________

Other_______________________________Home/Cell______________________Relationship______________________

Health Insurance: YES___NO___ Insurance Carrier______________________________Policy#___________________

Physician's Name________________Phone#___________Dentist's Name_______________Phone#_____________

The health services at Broward Junior Academy Summer Day Camp are to provide immediate first aid, administer medication and provide short-term care to campers until a parent or designated Emergency Contact can pick up the camper. A diagnosis cannot be made, nor are there facilities for extended periods of bed rest. We ask your cooperation in keeping sick children at home to prevent the spread of contagious illness.

Does your child have any restrictions on his/her activities? Yes _______ No _______

Does your child have any health needs, which require nursing care during camp hours? Yes _______ No _______

If yes, please specify: ____

____

The camp nurse has my permission to share my child's health information with his/her counselors: Yes ______ No _______

TO BE COMPLETED BY THE CAMPER'S PARENT/GUARDIAN

I grant the nurse, head of camp or his/her designee the permission to assist or perform the administration for each medication or treatment/procedure for my child during the camp day including when he/she is away from camp property for official camp events.

Note: * Prescription medications must be supplied in the original container. Ask the pharmacist to divide medication into **2 labeled containers**, one for home **AND** one for camp.
* Camp personnel may administer only prescription medications/treatments authorized by a physician.
* It is your responsibility to notify the camp when there is a change in medication/treatment regime.

I understand that (1) there is no liability on the part of the camp, its personnel, or agents, and hereby release and waive any claims or actions against such persons or entity as the result of the administration of this medication to my child when the person administering the medication acts as an ordinarily reasonably prudent person would have acted under the same or similar circumstances; (2) this medication must be brought to the camp only by a responsible adult; (3) this medication must be in its original labeled container; (4) this medication will be destroyed if it is not picked up within one week following the above stop date or one week after the close of the current camp session, or when prescription expires, whichever occurs first. I hereby authorize the exchange of medical information regarding my child's treatment plan between the physician and campus health personnel.

________________________________ ________________________________ ____________________
Parent/**Guardian Name (Print)** **Signature of Parent/Guardian** **Date**

If you have any questions or concerns please contact the clinic at 954-316-8301, Ext. 200

If I cannot be reached, I give Broward Junior Academy Summer Day Camp permission for emergency medical treatment, hospitalization, anesthesia, or necessary x-rays or injection, and will be responsible for the bills of same. This authorization does not include major surgery, unless life threatening, and only then when the medical opinion of two (2) licensed physicians or dentists concur in that treatment. I give my permission for the clinic staff/designee to administer approved medications to my child(ren).

(Both Parents or Custodial Parent must sign below.)

X Mother/Custodian ____ ________________________
Signature **Date**

X Father/Custodian ____ ________________________
Signature **Date**

Information will be valid for one (1) year

BROWARD JUNIOR ACADEMY SUMMER DAY CAMP

PERMISSION FOR OVER-THE-COUNTER MEDICATION

PERSONAL AND CONFIDENTIAL

By **Law**, we are unable to administer **ANY PRESCRIPTION MEDICATION** without the authority of a physician. If your child needs to receive his/her prescription medicine during camp hours, the medication must arrive in a pharmacist's container, with the label clearly stating the child's name, the name of the medicine, the dosage, the frequency of the dose & the completed Authorization for Medication form. The Clinic Nurses will provide name brand; over-the-counter comfort remedies for the child with this completed Authorization, **signed** by the parent/guardian of the camper.

CAMPER NAME: ____ **DOB:** ____________________

Medical History: (Please list all medications taken at home or during the school year)

Allergies: YES___ List____ NO___
*Medication*____

Asthma: YES___ Explain____ NO___
*Medication*____

Autism: YES___ Explain____ NO___
____
*Medication*____

ADD or ADHD: YES___ Explain____ NO___
____
*Medication*____

Cardiac Disorders: YES___ Explain____ NO___
*Medication*____

Diabetes: YES___ Explain____ NO___
*Medication*____

Recent Surgery: YES___ Explain____ NO___
Date____________ *Medication*____

Seizure Disorders: YES___ Explain____ NO___
____
*Medication*____

List any allergy and diagnosis, or emergency precautions that the Clinic should anticipate for this child, i.e.: allergy triggers, diabetic reactions, etc. List all medications that are currently prescribed for this child. Include inhalers, Epipens, etc.

DIAGNOSIS	ORDERS – *Issued by United States licensed Physician*
1. ______________________________	______________________________

Side Effects & Specific Instructions ____

2. ______________________________	______________________________

Side Effects & Specific Instructions ____

◆Please **CROSS OFF MEDICATIONS** the camper **MAY NOT** have, and enter any additional OTC medications provided.

MEDICATION	DOSAGE	Route & frequency	INDICATIONS FOR USE
Acetaminophen (Tylenol)	po	per bottle instructions	headache or fever
Bacitracin Antibiotic Ointment	Topical	per package instructions	cuts and abrasions
Benadryl Elixir	po	per bottle instructions	allergic reactions
Benadryl Gel	Topical	per bottle instructions	itching or bug bites
Ibuprofen (Advil/Motrin)	po	per bottle instructions	headache, general pain

Other: ____

PARENT/GUARDIAN NAME PRINTED	PARENT/GUARDIAN SIGNATURE	DATE

◆PLEASE COMPLETE REQUIRED AUTHORIZATION FOR MEDICATION FORM FOR ALL PRESCRIPTION MEDICATION◆