Medical Pre-Consent Form

Today's date _____

Last name of Child_____ First name _____ Date of birth _____

I authorize healthcare personal to treat the above child in an emergency while attending and being cared for by the Fairmount Camp staff during the registered camp. I also authorize Fairmount camp to administer my child's daily medications and the checked over the counter medications on page 2. Basic treatments such as saline eye drops, cough drops, calamine lotion, triple antibiotic ointment and Vaseline may be administered by camp staff as needed.

_____
(signature of parent or guardian)

☐ **By checking this box I consent to the above statement and that my typed name above can be used as my signature.**

Home address_____

City _____ State _____ Zip _____

Home/mobile Phone _____ Work _____

Emergency Contact_____ Address_____ Phone _____

Childs Physician_____ Physician's Phone _____

Medications your child will take at camp:

Medications must be in their original bottle and within date

Parents, please complete this portion **Nursing staff, please complete this portion with time and initials**

Daily Medications:	Dose	Time of day to take	Monday	Tuesday	Wednesday	Thursday	Friday

Check each over the counter medication that you are ok for your student to receive while at camp:

Yes	As needed medication: provided by camp	Dose	Monday	Tuesday	Wednesday	Thursday	Friday
	Hydrocortisone cream						
	Tylenol						
	Ibuprofen						
	Benadryl						
	Tums						
	Mucinex						
	Chloraseptic throat spray						

Allergies and or reactions _____

Date of last tetanus booster_____

Has your child had any surgeries? ☐ **Yes** ☐ **No** **List surgeries**_____

Chronic or existing diseases or medical problems_____

_____

Medical Insurance Carrier_____**Holders name**_____

I.D. Number_____**Benefit code:**_____**Account number:**_____

**** The policy of the camping program states that in case of an accident that requires doctor or hospital care, the family insurance coverage is the primary coverage and the camp's insurance is the secondary.****

Within the last 24 hours have you had?

	Yes	No
Vomiting		
Diarrhea		
Fever		
Sore throat		
Sinus congestion		
Runny nose		
Other:		

Do you currently have or recently had lice? ☐ **Y** ☐ **N**

Are you being treated for: Fracture ☐ **Y** ☐ **N** **Sprain** ☐ **Y** ☐ **N** **Skin Infection** ☐ **Y** ☐ **N** **Infections** ☐ **Y** ☐ **N**

Have you been out of the country within the past 30 days? ☐ **Y** ☐ **N**

Have you tested positive for COVID 19 in the past 90 days? ☐ **Y** ☐ **N**

THIS SECTION FOR NURSE'S USE ONLY

Dorm #_____ **Counselor**_____**Room #**_____

Campus nurse printed name_____ **Nurse signature**_____ **Date**_____