

# READ THE FOLLOWING

## STEPS FOR COMPLETING CAMP MILLHOUSE MEDICATION FORMS

**THE ORIGINAL WHITE MEDICATION SHEET AND THE GREEN HEALTH FORM MUST BE IN THE OFFICE TWO WEEKS PRIOR TO CAMPERS ARRIVAL OR THE CAMPER WILL NOT BE ABLE TO ATTEND!! I understand this policy and agree to abide by it .**

- There can be NO medication changes, within 14 days prior to your campers arrival. This includes increases or decreases of the dosage, additions or deletions of medication. IF there are such changes you must contact the office as you WILL need to reschedule camp. The one exception to this is if your camper was put on an antibiotic, then you MUST have a copy of the prescription signed by the PHYSICIAN.
- Please send just enough medication for the week and one extra dosage incase of an emergency.
- Copy the name of the medication and the directions for administration onto the form under the name of the medication
- Medication will be given at **8:00am, 12:00pm, 5:00pm and 8:00pm** unless otherwise specified by the camper's Physician.
- ALL MEDICATIONS MUST BE IN THE ORIGINAL BOTTLE WITH THE Matching PHARMACY LABELS INTACT. NO EXCEPTIONS!!!
- MEDICATION FORM MUST BE SIGNED BY THE CAMPER'S PHYSICIAN. NO EXCEPTIONS!
- INFORMATION ON THE MEDICATION FORM MUST MATCH EXACTLY TO THE NAME AND DOSAGE LISTED ON THE BOTTLE.
- PRN's must accompany campers to camp. The same procedures apply in regards to the original containers.
- VITAMINS MUST ALSO BE INCLUDED ON THE WHITE MEDICATION FORM. NURSES ARE NOT ALLOWED TO DISPENSE ANY MEDICATIONS/ VITAMINS THAT DO NOT APPEAR ON THE SIGNED MEDICATION FORM.
- IF your Child/ Client uses a feeding pump or uses a "UP-Draft" machine we ask that you bring these items with them to camp. The Rate and Dosage of food and medication MUST BE ON THE WHITE MEDICATION SHEET.

**I have read and understand the policies and procedures listed above in regards to medication and vitamins. Please leave this sheet attached to the white medication sheet.**

Signature of parent/guardian\_\_\_\_\_ Date\_\_\_\_\_

Camp Millhouse 2007\*Health Form  
25600 Kelly Road \* South Bend, IN. 46614

**PLEASE ENCLOSE A COPY OF INSURANCE CARD (S)**

**IDENTIFICATION/INSURANCE**

Name \_\_\_\_\_ Sex    M    F  
Age at time of attendance \_\_\_\_\_ Date of Birth \_\_\_\_\_ S.S. # \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_  
Day phone \_\_\_\_\_ Evening phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Parent/Guardian Name(s) \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_  
Day Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**EMERGENCY CONTACT (TWO CONTACTS NOT OF THE SAME HOUSE HOLD)**

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Day Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Day Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**INSURANCE**

Company Name \_\_\_\_\_  
Policy Number \_\_\_\_\_ Phone \_\_\_\_\_  
Medicaid/Other Numbers \_\_\_\_\_  
Dentist/Orthodontist \_\_\_\_\_ Phone \_\_\_\_\_

**Health History - Please list dates where applicable**

**Chronic Conditions**

- Diabetes
- Heart Conditions
- Seizures (please list typical seizure activity and length)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- Asthma
- Bone/Joint problems
- Head Injury
- Hepatitis A B or C
- HIV Positive
- Other \_\_\_\_\_
- \_\_\_\_\_
- Circulatory Cond.

**Allergies**

- Latex
- Medication (please list)  
\_\_\_\_\_  
\_\_\_\_\_
- Insect bites
- Grass, molds ect.
- Foods (please list)  
\_\_\_\_\_  
\_\_\_\_\_
- Other  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MISC. Information**

- Straight Cath. (frequency) \_\_\_\_\_
- Foley Cath
- Ostomy \_\_\_\_\_
- G-Tube (please provide rate and times of feedings. You will need to provide your own pumps, supplies and food) \_\_\_\_\_
- \_\_\_\_\_
- C-Pap
- Oxygen
- Ear Infections
- Bleeding problems
- Fainting spells
- Hernia
- Chicken Pox
- Mumps
- Mono
- Swallowing problems
- TB (date) \_\_\_\_\_
- Foot Problems \_\_\_\_\_
- Skin Conditions: Dry Eczema Bruising  
Scrapes Open wounds Cellulites

**Please list any surgeries or hospitalizations in the past 5 years:**  
\_\_\_\_\_  
\_\_\_\_\_

Camp Millhouse 2007\*Health Form  
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**Please fill out the immunizations below or the form will be returned.**

Type	Date(s)	Type	Date(s)
Tetanus		MMR	
Polio		Hep A	
TbTest		Hep B	

**PERMISSION TO TREAT**

I hereby give permission to the medical personnel selected by the camp director to provide routine health care; to administer medications; to order x-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/my child/client. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. I hereby give permission for the named above to engage in all prescribed camp activities, appropriate for age and ability, except as noted. This completed form may be photocopied for trips out of camp.

Parent/Legal guardian signature \_\_\_\_\_  
Witnessed by \_\_\_\_\_

**Medical exam to be conducted within 6 months of campers/ staff arrival to camp by the camper PRIMARY PHYSICIAN!**

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Does the applicant have Down Syndrome? \_\_\_Yes \_\_\_ No If yes: Applicant has \_\_\_positive \_\_\_ negative evidence of Alanto-Axial Instability, or \_\_\_ unknown/no x-ray.

The applicant is under the care of this physician for: \_\_\_\_\_  
\_\_\_\_\_

Current treatment: \_\_\_\_\_  
Current Medications: \_\_\_\_\_

**MEDICATIONS ARE ADMINISTERED AT 8 - 12 - 5 - 8 IF THIS IS A PROBLEM PLEASE LIST TIMES MEDS SHOULD BE GIVEN:** \_\_\_\_\_

Please list any activity restrictions the camper/staff may have: \_\_\_\_\_  
\_\_\_\_\_

<p><b>Primary Care LICENSED PHYSICIAN'S SIGNATURE</b> _____</p> <p><b>PRINTED NAME</b> _____</p> <p><b>ADDRESS</b> _____</p> <p><b>CITY</b> _____ <b>STATE</b> _____ <b>ZIP</b> _____ <b>PHONE</b> _____ <b>FAX</b> _____</p> <p><b>DATE FORM COMPLETED</b> _____ <b>BY WHOM</b> _____</p>
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Camper's Name \_\_\_\_\_

Camp Millhouse Medsheet

Session Date \_\_\_\_\_

Medication	Time	Sun	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.
Example Prednisone 5mg 4 times a day by mouth	8:00am							
	12:00pm							
	5:00pm	<b>This Space is for Camp Medical Staff Only!</b>						
	9:00pm							

Medication	Time	Sun	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.

Medication	Time	Sun	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.

Medication	Time	Sun	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.

Medication	Time	Sun.	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.

Medication	Time	Sun	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.

Medication	Time	Sun	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.

Medication	Time	Sun	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.

Primary Physician Signature \_\_\_\_\_  
 Printed Name of Primary Physician \_\_\_\_\_

<b>Camper takes Meds</b> <input type="checkbox"/> Whole <input type="checkbox"/> Crushed <input type="checkbox"/> In Juice <input type="checkbox"/> Applesauce <input type="checkbox"/> Pudding <input type="checkbox"/> Placed in hand	<b>Camper has a Tube feeding</b> Receives a total of _____ per day. Pump is set to the rate of _____ For _____ Hrs.	<b>Camper has the following</b> <input type="checkbox"/> Foley Cath <input type="checkbox"/> Straight cath _____ times a day <input type="checkbox"/> Ileostomy <input type="checkbox"/> Colostomy	<b>Diabetic</b> <input type="checkbox"/> Blood Sugar checked _____ <input type="checkbox"/> Insulin Please include sliding scale signed by primary physician.
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PLEASE TURN OVER

