

**CAMP KESHER
MEDICAL INFORMATION AND AUTHORIZATION FORM**

Participant, Parent, or Guardian: Please submit this form to us by June 1, 2010. **No camp participant will be permitted to stay on the grounds without having submitted a Medical Information and Authorization Form. All medication and drugs must be turned over to the Camp Nurse upon arrival at camp.**

Please notify the camp if the participant has been exposed to any communicable diseases during the three weeks prior to camp attendance, and/or carries or suffers from a health condition that can be transmitted to another person.

Please be sure to give us ALL medical Information for your child's well being.

Participant's Name _____ Age _____ Sex _____ D.O.B. _____

(if under 18) Parent/Guardian's Name(s) _____

Address _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

Emergency Contact Person _____ Phone # _____

Doctor's Name _____ Phone # _____

Medical Insurance Company _____ Phone # _____

Address _____ Group or Plan # _____

A. Is this the Camper's first sleep-away-from-home experience? _____

B. Immunization Record (give dates, including dates of basic immunization and date of last booster):

Polio Vaccine _____ Tetanus _____

Measles _____ Mumps _____

Rubella _____ DPT/TD _____

Others _____ TB Test given: _____

C. Allergies (including food and/or drug allergies): _____

D. Medications (all medications MUST be sent in the original container with the child's name and the instructions from the doctor clearly stated):

<u>Medication</u>	<u>Amount</u>	<u>Time to be Given / Other Instructions</u>
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Mail to: CAMP KESHER, PO BOX 541, GREENBELT, MD 20768-0541

The following over-the-counter medications may be given, if needed: All None Below
 Cough Lozenges Antibiotic Ointment Benadryl
 Cough Syrup / Robitussin CF Anti-Diarrheal (i.e., Imodium) Tylenol / Advil
 TUMS, Maalox, Pepto Bismol Anti-Itch Cream (i.e., Benadryl/Hydrocortisone)

E. Note special limitations or dietary information Camp Keshar should know about: _____

F. Authorization for Medical or Surgical Care: This health history is correct and the person herein described has permission to engage in all camp activities, except as noted above. I hereby give permission and authorize any certified staff member (Nurse/Director) of Camp Keshar to call an authorized physician or medical personnel to administer medical aid and treatment for the health of the participant named above at any time they believe an emergency exists.

 (Printed Name of Participant) (Signature) (Date)

If Participant is under age 18:

 (Printed Name of Mother/Guardian) (Signature) (Date)

 (Printed Name of Father/Guardian) (Signature) (Date)

 (Printed Name of Witness and Phone Number) (Signature) (Date)