**MEDICATION CONSENT FORM**

If medication consent form is not **FULLY completed and signed** by parent, medications will **NOT** be administered to the camper!

The following medications will be administered as needed **ONLY if initialed** by parent/guardian.

<table>
<thead>
<tr>
<th>Initial</th>
<th>Medication</th>
<th>Dose</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>____</td>
<td>Tylenol 325 mg(adult)</td>
<td>2 tabs</td>
<td>every 4-6 hr</td>
</tr>
<tr>
<td>____</td>
<td>Tylenol 160 mg(Jr)</td>
<td>2 tabs</td>
<td>every 4-6 hr</td>
</tr>
<tr>
<td>____</td>
<td>Ibuprofen(Motrin) 200 mg</td>
<td>___tabs</td>
<td>every 4-6 hr</td>
</tr>
<tr>
<td>____</td>
<td>Motrin 100 mg(Jr)</td>
<td>___tabs</td>
<td>every 6-8 hr</td>
</tr>
<tr>
<td>____</td>
<td>Decongestant</td>
<td>___tabs</td>
<td>every 6 hr.</td>
</tr>
<tr>
<td>____</td>
<td>Cough drops</td>
<td>1 drop</td>
<td>every hour</td>
</tr>
<tr>
<td>____</td>
<td>Benadryl 25 mg</td>
<td>___caps</td>
<td>every 6 hr</td>
</tr>
<tr>
<td>____</td>
<td>Benadryl Elixir(25 mg/tsp)</td>
<td>___tsp.</td>
<td>every 6 hr</td>
</tr>
<tr>
<td>____</td>
<td>Guaifenesin DM(coughs)</td>
<td>2 tsp.</td>
<td>every 4 hr.</td>
</tr>
<tr>
<td>____</td>
<td>*100 mg/10mg per 5 ml</td>
<td></td>
<td></td>
</tr>
<tr>
<td>____</td>
<td>Cortisone Cream</td>
<td>topical</td>
<td>every 4-6 hr</td>
</tr>
<tr>
<td>____</td>
<td>Triple antibiotic Ointment</td>
<td>topical</td>
<td>as needed</td>
</tr>
<tr>
<td>____</td>
<td>Alamag Plus(antacid)</td>
<td>2 tabs</td>
<td>every 4-6 hr</td>
</tr>
<tr>
<td>____</td>
<td>Anti-nausea medication</td>
<td>1-2 tabs or 1 Tbsp. daily</td>
<td></td>
</tr>
<tr>
<td>____</td>
<td>*(vomiting)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>____</td>
<td>*Loperamide 2mg</td>
<td>2 initially, then 1 after next loose BM</td>
<td></td>
</tr>
<tr>
<td>____</td>
<td>*(diarrhea mediation)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**REQUIRED PARENT/GUARDIAN CONSENT**

This medical history/medication consent form is correct as far as I know. I understand that both forms must be filled out COMPLETELY and signed by parent/guardian in order for my child to receive treatment at this HSU camp. I understand that in the case of an emergency, every effort will be made to contact a parent/guardian prior to treatment. If a parent or guardian cannot be reached, however, and the situation requires immediate emergency attention as determined by camp staff, I hereby authorize representatives of the camp to obtain emergency treatment for my child as deemed necessary by representatives of the camp.

I agree to the release of any records necessary for treatment or referral of the minor child.

**MEDICATION, PRESCRIPTIONS:**

Arkansas State Law **requires** parental authorization to administer any prescription medications brought by campers. Prescribed medication **MUST** be in its original container with the pharmacy label showing number, patient name, date filled, physician name, name of medication, and directions for use. **I authorize the camp health care supervisor to administer to my child any prescribed medication being brought to camp.**

**NON-PRESCRIPTION MEDICINES:**  I authorize the health care supervisor or designated First Aider to administer the non-prescription medications that I have INITIALED above in brand name or generic form if necessary for camper’s comfort.

**ANY MEDICATIONS NOT INITIALED BY PARENT/GUARDIAN WILL NOT BE ADMINISTERED TO CAMPER AT ANY TIME**

**REQUIRED PARENT SIGNATURE**

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DATE

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PRINT NAME

...
REQUIRED MEDICAL HISTORY & CONSENT FOR TREATMENT-ALL CAMPS

Camp child will be attending: _________________________________ Dates __________________
Camper’s full name _________________________________ Date of birth __________________
E-mail address _________________________________
Street address _________________________________
City __________________ State __________ Zip ________________
Parent/guardian __________________ am phone __________ pm phone __________
Parent/guardian address ________________________________
Parent/guardian __________________ am phone __________ pm phone __________
Parent/guardian address ________________________________
IN CASE OF EMERGENCY, if parent/guardian cannot be reached, name of person to notify or to whom we can release camper:
Name __________________ am phone __________ pm phone __________

UNDER NO CIRCUMSTANCES SHOULD CAMPER BE RELEASED TO: ____________________________

CHECK ALL CAMPER HAS OR HAD HAD:
Constitution Bedwetting sleepwalking swimmer/abscessed ear mumps
Convulsions homesickness asthma frequent colds nausea
Tuberculosis chicken pox heart trouble scarlet fever polio
Diabetes measles bronchitis appetite loss sinusitis
Glasses contacts kidney trouble frequent sore throat rheumatic fever

Of all the above, these are current or recurring: ______________________________________

ALLERGIES: bee stings drugs ________________ foods: ________________ other: ________________
Recently exposed to contagious disease? Y N If yes, which? ____________________________
Menstruates? Y N menstruation normal? Y N if no, explain ____________________________ knows about it? Y N
If hospitalized within past 5 years, explain __________________________________________
Describe physical conditions requiring restrictions on participation in camp program ________________

Name of camper’s physician or health care provider ________________________________
Address __________________________________________ Member number ______________
Insurance Company __________________________________________ Insurance Company address

A COPY OF CURRENT IMMUNIZATION RECORD MUST BE ATTACHED OR PHYSICIAN MUST COMPLETE AND SIGN THE FOLLOWING:

IMMUNIZATION MONTH/YEAR REQUIRED BY THE DEPT. OF PUBLIC HEALTH WITH PHYSICIAN’S SIGNATURE
Hepatitis B(3, DOB after 1/92) ________________ ________________ ________________
Polio(3-4) ________________ ________________ ________________
Diphtheria, tetanus, pertussis(4) ________________ ________________ ________________
Mumps, measles, rubella(2) ________________ ________________
Tuberculin tests(Tb) ________________ ________________
Physician’s signature(required) ____________________________ Date of signature ________________
Physician’s name or official stamp ___________________________________________ phone number ________________

Parent/Guardian signature ____________________________

Print Parent/Guardian Name ____________________________ Date __________________