



**ALL PARENTS SHOULD COMPLETE THIS TOP HALF**

Do you give Camp West Woods permission to administer the following?

- |     |     |   |
|-----|-----|---|
| Yes | No  |   |
| ___ | ___ | Sunscreen (PABA free)   |
| ___ | ___ | Insect repellent (spray or lotion)  |
| ___ | ___ | Tylenol (acetaminophen) for fever greater than 101.5 degrees F.   |
| ___ | ___ | Ibuprofen for headache or muscle pain   |
| ___ | ___ | Benadryl or equivalent for unusual bee sting reaction   |
| ___ | ___ | Benadryl or equivalent for hives. Administration of this medication will be followed by phone notification by Health Supervisor to parent/guardian. |

**Insect Sting Allergy Information:**

Type of insect: \_\_\_\_\_ Last stung: \_\_\_\_\_

Reaction to sting (in detail): \_\_\_\_\_

Treatment: \_\_\_\_\_

Will you be providing an EPI-Pen Jr. for your child? Yes \_\_\_ No \_\_\_ (EPI-Pen Jr. will be given automatically to prevent anaphylactic shock.)

**Asthma:**

Last episode: \_\_\_\_\_ How often? \_\_\_\_\_

Triggers: \_\_\_\_\_ Symptoms: \_\_\_\_\_

Treatment: \_\_\_\_\_

I hereby certify that the above named camper is in good health and fully able to participate in all activities except those stated above. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Director of Camp West Woods to hospitalize and/or secure treatment for my child.

Date \_\_\_\_\_ Signature \_\_\_\_\_ If for religious reasons you cannot sign this, the camp should be contacted for a legal waiver which must be signed prior to enrollment.

**To Be Completed by parents who are bringing medication to camp for their child**

I hereby give permission to the Qualified Staff of Camp West Woods to administer the following medications to my child

**First Medication:**

Name of medication: \_\_\_\_\_

When to be given: \_\_\_\_\_

Doctor who prescribed: \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Any further instructions of medications will be sent in writing to the Health Staff of Camp West Woods.

Signature of Parent: \_\_\_\_\_

**Second Medication:**

Name of medication: \_\_\_\_\_

When to be given: \_\_\_\_\_

Doctor who prescribed: \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Any further instructions of medications will be sent in writing to the Health Staff of Camp West Woods.

Signature of Parent: \_\_\_\_\_