

Shiloh Park

Children's Summer Camps 2018



Camper Medical Form

Child's Full Name _____ **Birthdate** ____/____/____

I give my permission for the above named child to participate in all camp activities including but not limited to climbing, swimming, kayaking, and water sliding. I hereby authorize the staff and volunteers of Shiloh Park camp and NEI, NWI, INDY children's camp to administer basic medical first aid and emergency medical or dental treatment if needed and to seek medical treatment from a hospital or doctor. I give permission for the camp nurse to administer medications as directed (**medications listed on reverse side of this form**). I give permission for my child to be photographed or videotaped for camp promotional materials or social media.

I give permission for my child to be given: ___ Tylenol ___ Ibuprofen ___ Benadryl

Parent or Guardian (printed name) _____ **Date** _____

Signature of parent or guardian _____

Address _____ City, State, Zip _____

Parent /Guardian phone number(s) _____

Secondary Emergency Contacts

Name: _____ Relationship to child _____ Phone _____

Name: _____ Relationship to child _____ Phone _____

Family Doctor _____ Phone _____

Medical Insurance Carrier _____ ID # _____

Name of Insured _____

Church Name _____ Campers WILL be released to ride home in your **church van or bus** if provided. If your camper will NOT be riding home in a vehicle provided by your church, please provide the name of the AUTHORIZED PICK UP PERSON: _____ (Please call Shiloh Park to make changes)

Camper Personal Information

Date of Last Tetanus Shot ____/____/____ Allergies and medical conditions _____

Is there anything else that we should know about your child to best care for him/her? _____

****** NEW! Lice checks will NOT be offered upon arrival! This MUST be completed PRIOR to coming to camp!******

Head Lice Inspection (must be completed by a licensed medical professional or cosmetologist)

"I certify that the child named above shows no evidence of lice, nits, or eggs."

Signed _____

Credentials/Title _____ Date ____/____/____

To be completed by camp staff: _____ Passed Temp. Check

Child's Name _____ Age _____ Weight _____

This box to be completed by camp staff:

Cabin _____ Counselor Name _____ Phone _____

Nurse Initials _____ Printed Name _____ Signature _____

Parent Please Complete:		To be completed by the nurse							
Medication	Check when to be given	Day 1 Date:		Day 2 Date:		Day 3 Date:		Day 4 Date:	
		Clock	Init	Clock	Init	Clock	Init	Clock	Init
Dosage	Breakfast								
	Lunch								
Reason / Special Instructions	Dinner								
	Bedtime								
	As Needed								
Medication	Check when to be given	Day 1		Day 2		Day 3		Day 4	
		Clock	Init	Clock	Init	Clock	Init	Clock	Init
Dosage	Breakfast								
	Lunch								
Reason / Special Instructions	Dinner								
	Bedtime								
	As Needed								
Medication	Check when to be given	Day 1		Day 2		Day 3		Day 4	
		Clock	Init	Clock	Init	Clock	Init	Clock	Init
Dosage	Breakfast								
	Lunch								
Reason / Special Instructions	Dinner								
	Bedtime								
	As Needed								
Medication	Check when to be given	Day 1		Day 2		Day 3		Day 4	
		Clock	Init	Clock	Init	Clock	Init	Clock	Init
Dosage	Breakfast								
	Lunch								
Reason / Special Instructions	Dinner								
	Bedtime								
	As Needed								