



# Student Health Information

Please Print Clearly

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Male  Female Parent/Guardian name: \_\_\_\_\_ Teacher \_\_\_\_\_

## Medical History

1. Date of last routine health or physical exam: mo. \_\_\_\_\_ yr. \_\_\_\_\_  
Performed by: (doctor or clinic) \_\_\_\_\_

2. Check or circle any of the conditions which apply to your child:

- |  |  |
|--|--|
| <input type="checkbox"/> Allergies: (type) _____   | <input type="checkbox"/> Diabetes  |
| _____  | <input type="checkbox"/> Hearing problems: Aid <input type="checkbox"/> yes <input type="checkbox"/> no        |
| <input type="checkbox"/> Asthma: Medication <input type="checkbox"/> yes <input type="checkbox"/> no | <input type="checkbox"/> Vision/eye problems: Glasses <input type="checkbox"/> yes <input type="checkbox"/> no |
| <input type="checkbox"/> Bone/joint injury or disorder   | <input type="checkbox"/> Nasal condition   |
| <input type="checkbox"/> Chronic headaches   | <input type="checkbox"/> Heart condition   |
| <input type="checkbox"/> Convulsive disorders  | <input type="checkbox"/> Kidney/urinary tract disease  |
| <input type="checkbox"/> Frequent infections   | <input type="checkbox"/> Rheumatic fever   |
| <input type="checkbox"/> Ulcers, colitis, intestinal problem (please specify) _____                  | <input type="checkbox"/> Other (specify) _____   |

3. Is your child presently taking any prescribed or over-the-counter medication?  No  Yes  
(List medication) \_\_\_\_\_

4. Will medication need to be administered at camp?  yes  no *If yes, see the school nurse for procedures & forms.*

5. Has your child had surgery, an injury, a disability, or specific health conditions which might limit your child's activities at camp? *Explain* \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Signature of person providing health information Relationship Date**

Parent /Guardian Phone: home \_\_\_\_\_ work \_\_\_\_\_ cell \_\_\_\_\_

## Emergency Care

It is vitally important for the safety and well-being of your child that (2) additional names (not your own) be listed below for emergency contact/release in the event that you cannot be reached.

**1<sup>st</sup> contact person** \_\_\_\_\_ Relationship \_\_\_\_\_

Phone: home \_\_\_\_\_ work \_\_\_\_\_ cell \_\_\_\_\_

**2<sup>nd</sup> contact person** \_\_\_\_\_ Relationship \_\_\_\_\_

Phone: home \_\_\_\_\_ work \_\_\_\_\_ cell \_\_\_\_\_

I give my permission for school or camp personnel to call the listed doctor in case of emergency and I cannot be located. **Doctor** \_\_\_\_\_ **Phone** \_\_\_\_\_

Family Medical Insurance  no  yes Name of Insurance Co. \_\_\_\_\_

\_\_\_\_\_  
**Signature of parent or guardian Date**

# Medication Procedure



## Flagstaff Unified School District

All prescription, and over-the-counter medications (including vitamins, Tylenol or Ibuprofen, etc.) must be delivered to your child's classroom teacher by the Wednesday prior to class departing to camp. Students are not allowed to keep any medications with them. Please send only the amount of medication needed during camp in the original labeled container. All prescription medicine must be recently prescribed by a physician licensed in Arizona for the child to whom you wish it administered. Medication cannot be shared and can only be administered to the person listed on the label. Please complete and sign the student health information form included for **each** type of medication needed. You may make additional copies of this form if needed.

*Thank you for helping us keep your child safe while at camp.*

### Request for Medication at Camp Colton

Name \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_

Medication \_\_\_\_\_ Dosage \_\_\_\_\_ Reason \_\_\_\_\_

Time to be given \_\_\_\_\_ AM \_\_\_\_\_ PM (or) As Needed  explanation: \_\_\_\_\_

Prescriber's Name \_\_\_\_\_ Known Drug or Food Allergy to \_\_\_\_\_

Any additional information \_\_\_\_\_

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Name \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_

Medication \_\_\_\_\_ Dosage \_\_\_\_\_ Reason \_\_\_\_\_

Time to be given \_\_\_\_\_ AM \_\_\_\_\_ PM (or) As Needed  explanation: \_\_\_\_\_

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Any additional information \_\_\_\_\_

### Request for Medication at Camp Colton

Name \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_

Medication \_\_\_\_\_ Dosage \_\_\_\_\_ Reason \_\_\_\_\_

Time to be given \_\_\_\_\_ AM \_\_\_\_\_ PM (or) As Needed  explanation: \_\_\_\_\_

Prescriber's Name \_\_\_\_\_ Known Drug or Food Allergy to \_\_\_\_\_

Any additional information \_\_\_\_\_

I hereby request and give my consent for the Camp Colton designated staff to give the above named medication to my child. This request includes authorization for the Camp Colton staff to contact a health care provider when necessary. I agree to notify the Camp Director immediately by phone of any change in medication, dose or time of day for the administration.

\_\_\_\_\_  
Please print Parent / Guardian name

\_\_\_\_\_  
Parent / Guardian Signature

\_\_\_\_\_  
Date

All medication must be in the original container as prepared by a pharmacist and labeled to include the patient name, name of the medication, dosage and time to be given. All prescribed and over-the-counter medication must be in the original packaging, with all the directions, dosages, compound contents and proportions clearly marked.