

All parents/guardians should complete this top half

Do you give Camp Triumph permission to administer the following:

Yes No

___ ___ Sunscreen (PABA free)

___ ___ Insect Repellant (Spray or Lotion)

___ ___ Tylenol (for headache or fever greater than 101.5 degrees F.)

___ ___ Benadryl (if stung or for unusual bee sting reaction)

___ ___ Benadryl (if hives develop) Administration of this medication will be followed by phone notification by Health Supervisor to parent.

Insect Sting & Allergy Information:

Type of insect: _____ Last stung: _____

Reaction to sting (in detail): _____

Treatment: _____

For insect stings and other applicable allergies an EPI-PEN must be provided by parents/guardian.

Asthma:

Last episode: _____ How often? _____

Triggers: _____ Symptoms: _____

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 Triumph 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/guardians who are bringing medication to camp for their child

I hereby give permission to the Health Staff of Camp Triumph to administer the following medications to my child:

* Medications must be in original prescription bottle.

*Please note that medications are administered only at the following times:

10:30 a.m., 12:00 p.m. and 1:30 p.m.

First Medication:

Name of medication: _____

When to be given: ___ 10:30 a.m. ___ 12:00 p.m. ___ 1:30 p.m.
(Check all that apply)

As prescribed by Doctor _____ Phone _____

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

Signature of Parent: _____

Second Medication:

Name of medication: _____

When to be given: ___ 10:30 a.m. ___ 12:00 p.m. ___ 1:30 p.m.
(Check all that apply)

As prescribed by Doctor _____ Phone _____

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

Signature of Parent: _____