

CAMP HERRLICH BEFORE SCHOOL PROGRAMS
MEDICAL INFORMATION FORM

Child's Name (please print) _____ Date of Birth _____

Address _____ Home Phone _____

Mom's Name _____ Dad's Name _____

Mom's Work Phone _____ Dad's Work Phone _____

Mom's Cell Phone # _____ Dad's Cell Phone _____

Please rank phone numbers 1 through 4 in the order you would like them called in the event of an emergency

Name of Child's Physician _____ Phone _____

Name of Child's Dentist _____ Phone _____

Medical Insurance Company _____

Insured Person _____ Policy Number _____

Medical Insurance Company _____

Insured Person _____ Policy Number _____

The following are names of people other than myself who can be contacted **IN CASE OF AN EMERGENCY, AND/OR MAY PICK UP MY ILL CHILD** if I cannot be reached. **You must list someone besides yourself & your spouse.**

<u>Name</u>	<u>Relationship</u>	<u>Phone</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

In the event of an emergency I, _____, authorize a Camp Herrlich Before School Staff Member to take my son or daughter to the hospital for treatment at my own expense. I further give my consent that any emergency medical care needed may be given to my son or daughter _____ in case I cannot be reached.

Parent/Guardian Name (Please Print) _____

Signature of Parent or Guardian _____ Date _____

Please check any allergies your child may have, and provide any pertinent information. **This is the only record of medical information we have on your child. It is important that you fill this out honestly and completely. It is for your child's well-being and safety.** Please mark N/A for all those that do not apply.

ASTHMA _____ FOOD _____

INSECT BITES OR STINGS _____ LATEX? _____

MEDICATIONS _____

OTHER ALLERGIES (Please explain) _____

Is your child presently taking prescription medications for any health problems? If yes, please explain.

Will these medications be taken during the Before School Program? _____

Is your child presently taking over the counter or non-prescription medications for any health problems? If yes, please explain and list medications.

Will these medications be taken during the Before School Program? _____

According to New York State Childcare Regulations, prescription and over the counter medication may be administered only upon written permission of the parent and written instructions from a health care provider stating that the program may administer such medication and specifying the circumstances, if any, under which the medication or prescription must not be administered. Medication must be in the original container labeled with the child's complete name, the medication name, recommended dosage, time intervals for administration, method of administration, expiration date and, for prescription medication, the prescriber's name and license number. In accordance with NYS Office of Children and Family Services (OCFS), each before and after school site has a certified Medication Administration Trained provider on staff. All OCFS guidelines for medication administration will be followed.

Are there any restrictions that your child is presently under or will be under during the Before School Program that we should be aware of?

Are there any special health or dietary needs or problems we should be aware of?

PLEASE MAKE SURE THAT THE MEDICAL FORM IS COMPLETELY FILLED OUT BEFORE SUBMITTING WITH YOUR REGISTRATION FORM. THANK YOU.

This is a two-sided document →