

HEALTH FORM 2020
Due BEFORE MAY 15, 2020

Session _____

The information requested below will enable the director and staff to understand and serve your child's needs while at camp, and will facilitate any medical attention required due to illness or injury. It is therefore of vital importance that this statement be completed and signed by you and your physician. PLEASE BE AS COMPLETE AND HONEST AS YOU CAN FOR THE BENEFIT OF YOUR CHILD.

Child's Name _____ Birth Date _____ Age _____

Address _____
City, State, Zip _____

Parent/Guardian 1 Name _____ Work Phone (____) _____ Cell(____) _____

Parent/Guardian 2 Name _____ Work Phone (____) _____ Cell(____) _____

Place of Employment Parent 1 _____ Parent 2 _____

Name and telephone number, we should call in an emergency if we could not reach either parent:

Name _____

Phone (____) _____

TO BE COMPLETED BY PHYSICIAN

Date of last examination by physician _____

Physician's Name _____ Phone (____) _____

Address _____

Height _____ Weight _____ General Health: _____ very good _____ good _____ fair _____ poor

Are all immunizations and boosters current? _____ Yes _____ No (if no, please specify below)

Restrictions on activities: None _____ Sports _____ Swimming _____ Other _____
(Please Specify)

Restrictions on diet _____

Allergies: (Please List)

Are there any health conditions of which the CK staff should be aware? (Examples: Diabetes, epilepsy, chronic sore throats or stomach trouble, ADHD, Depression, Anxiety, Autism, Sleep walking, School Problems-suspension from school, etc.)
_____ Yes _____ No (If yes, provide details below)

☒ Physician's Signature _____ Date _____

☒ Parent's Signature _____ Date _____

TO BE COMPLETED BY PARENT

Note: Signature REQUIRED in TWO places BELOW for acceptance of application.

Child's Name _____
Please provide any information that would help the College for Kids staff better understand and relate to your child: **(Depression, anxiety... If your child takes a medication during the school year but not during CK, please let us know. Examples: ADHD, allergy, etc.)**

PROOF OF INSURANCE (mandatory for acceptance to program)

Name of Insurance Company _____ Policy # _____
Name of policy holder _____
Policy holder's social security # _____ (If needed for use of the policy.)

PERMIT AND RELEASE

_____ (my son/daughter) has my/our permission to participate in classes, activities, and field trips with College for Kids Faculty and Staff. I/we also grant permission for College for Kids or its designate to photograph, record, video tape my child; or use verbal or written material from my child during College for Kids activities and to use those materials for promotional or other purposes chosen by College for Kids Board of Directors. I/we authorize and constitute the College for Kids staff to act as my agent in obtaining medical or dental attention for my son/daughter by a licensed physician/dentist and/or hospital if illness or injury occurs while he/she is at camp. I/we also grant permission for medical personnel to obtain any information necessary for effective medical treatment of my/our son/daughter. I/we further agree (i) to indemnify and hold harmless the College for Kids, A Summer Exploration, Inc. director, staff, College for Kids Advisory Council and Board of Directors, cooperating sponsors, and Westminster College, and (ii) to forever refrain and desist from instituting or asserting any claim, demand, actions or suit for injuries or damage resulting from any accident or illness that might occur to my/our son/daughter while attending College for Kids, A Summer Exploration, Inc.

Parent/Guardian Signature: _____ **Date** _____
Signature REQUIRED ABOVE for Acceptance of Application

MEDICATION INSTRUCTIONS AND AUTHORIZATION

1. **Prescription Medications** must be in the original container from the pharmacy. Indicate dosage and schedule below. If your child is currently taking medication, please call CK in advance to ensure proper procedures are followed.

Name of Medication _____
Dosage and schedule _____
Additional instructions regarding prescription medication _____

2. **Non- Prescription over –the-counter medication** (Such as Tylenol, Pepto-Bismol, etc.) To be administered as needed per dosage directions for child's age and weight with **SIGNATURE below.**

PLEASE NOTE: This form MUST be signed BELOW to ensure proper medical attention during camp. I/we hereby authorize the staff of College for Kids to administer general first aid treatment, non-prescription medications, emergency medical help and prescription medications as per the above instructions, to my/our son/daughter while he/she is at camp.

Parent/Guardian Signature: _____ **Date** _____
Signature REQUIRED for Acceptance of Application

ALL MEDICATIONS MUST BE IN THE ORIGINAL BOTTLE WITH THE NAME OF THE MEDICATION AND DOSAGE FROM THE PHARMACY.