Safari Camper Health Information Summer 2019

Must be completed by camper's **parent or guardian** and returned no later than 2 weeks prior to the start of your child's first session.

All information will be held in confidence and will be released only to appropriate individuals.

Age Group: (please circle) **K 1 2-3 4-5 6-8**

Session/s: (please circle) **1 2 3 4 5 6 7 8 9 10 A B C D**

Please print clearly.

Child's name: _____ Age _____ Date of Birth _____

Address: _____

Parent/Guardian: _____ Email: _____

Day phone: _____ Evening phone: _____

Parent/Guardian: _____ Email: _____

Day phone: _____ Evening phone: _____

Emergency Information Additional emergency contacts: (other than parent/guardian)

_____

Name Phone No. Relationship

_____

Name Phone No. Relationship

Personal Physician: _____ Phone: _____

Address: _____

Health Insurance Co. _____ Policy No._____

Dietary restrictions: _____

Allergic reaction to medications: _____

Allergic reaction to bee stings/does this child carry a bee sting kit? _____

_____ Kit: Y N

Other allergies: _____

Heart/respiratory problems: _____ Asthma: Y N

Epileptic or other seizures:_____

Other medical conditions: (recent surgery, major illness, psychiatric treatment, etc.) _____

_____

Continued on back

Mail to: Seacoast Science Center, 570 Ocean Blvd., Rye, NH 03870 *or* **Fax to:** (603) 433-2235

Name

File Date

Session/s

rev. 12/18

Safari Camper Health Information Summer 2019

Continued from front side

Child's name: _____

Is child taking medication? Y N

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Inhaler: Y N **Medication must be provided in original, labeled prescription bottle.**

Does your child have any emotional and/or physical disabilities? Please explain:

_____

_____

Parental Authorization

In the event that I cannot be reached in an emergency, I hereby authorize the Seacoast Science Center staff or medical personnel to take emergency measures as needed.

_____

Signature of parent or guardian Date

I hereby release all Seacoast Science Center employees from all claims of liability for any injuries my child may sustain while attending camp.

_____

Signature of parent or guardian Date

Physician's Health Record Summer 2019

Must be completed by physician. (Or physician's records that are signed by the doctor.)

Safari Summer Camp at the Seacoast Science Center

Age Group: (please circle) **K 1 2-3 4-5 6-8**

Session/s: (please circle) **1 2 3 4 5 6 7 8 9 10 A B C D**

Child's Name: _____ Date of Birth:_____

Date of last tetanus booster:_____

Physician's Statement

I have examined _____ within the past 2 years.

In my opinion, his/her condition does not preclude participation in an active camp program.

Physician: _____ Phone: _____

Address: _____

_____	_____	_____
Signature of physician	Date form signed	Date last examined child

Name

File Date

Session/s

Mail or fax to:

SEACOAST SCIENCE CENTER

570 Ocean Boulevard, Rye, NH 03870 Ph: 603-436-8043 Fax: 603-433-2235 www.seacoastsciencecenter.org

rev. 12/18

Seaside Safari

Summer 2019

Permission for Dispensing Medication at Camp

My child, _____ , is required

by Doctor _____ to take the following medication(s):

1 Medication: _____

Dosage: _____ Time Schedule: _____

Method of taking: _____

Dates medication is needed: _____

Reason for medication: _____

Possible Adverse Reactions to Medication: _____

2 Medication: _____

Dosage: _____ Time Schedule: _____

Method of taking: _____

Dates medication is needed: _____

Reason for medication: _____

Possible Adverse Reactions to Medication: _____

Other medications: _____

MD's telephone: area code _____

Parent's cell/emergency telephone: area code _____

Other emergency contact name and telephone: area code _____

Prescription medications must be accompanied by a written order from the prescribing physician and must be in the original container with the prescription label. Dosage should not exceed that which is needed for child's time at camp. The medication must be delivered to the Camp Director by the parent or guardian. Children are not allowed to carry medication.

Over-the-counter medications that are deemed necessary by the parent or guardian and the camp staff (i.e. aspirin) require written permission of the parent only. The medication must be in the original container and a medication permission form completed.

I, the parent, authorize the Camp Nurse or any member of the Seacoast Science Center staff so designated by the Camp Director to assist* my child in taking the above stated medication.

I, the parent or guardian, agree by signing this request form and the "HOLD HARMLESS" statement that follows: I will not hold liable any member of the Seacoast Science Center staff who assists my child in the taking of the above medication.

* assist means having the required medication available to the child as directed and observing the child as he/she takes or does not take his/her medication.

Special Consideration for Epi-Pens:

I further acknowledge by signing this waiver that I have trained the Seacoast Science Center staff caring for my child in the proper technique for assisting with administering epinephrine. I am confident that my child and his/her counselors know how to use the epi-pen appropriately.

Parent/Guardian Printed Name: _____ Date: _____

Parent/Guardian Signed Name: _____ Date: _____

Name

File Date

Session/s

Group

SEACOAST SCIENCE CENTER

rev. 12/18

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