This form can be filled by using Adobe Acrobat Reader. This application is available by free download. Make sure to click the "Sign" button to start filling in the form.

CAMP VICTORY
HEALTH & EMERGENCY FORM

Return completed form to P.O. Box 711, Ocean Park, WA 98640

Must be delivered before Camp

All information will be held in strictest confidence

Camper Name_____ Date of birth_____ Age_____

Home Address_____ City_____ Zip_____

Parent/Guardian Name_____ Phone_____

Emergency Contact (not listed above):

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

Prescription or Over-the-Counter Medications your child is currently taking:

All medications (except inhalers) must be in original pharmacy containers which includes dosage and physician information and will be kept and dispensed by the Camp Nurse. If more than one medication is given, please use the form on reverse.
Staff will hold and dispense medication according to physician instructions or instructions on the over-the-counter medication.

Medication Name_____ Amount (mg.)_____

Does medication require refrigeration? ☐ Yes ☐ No

Times given or as needed (reason)_____

Allergies, dietary needs or medical problems we need to be aware of:_____

_____

Has your child been treated for head lice within the past month?_____

Has your child received professional counseling during the past two years?_____

Name of Counselor:_____ Phone_____

Your Child's Physician:_____ City_____ Phone_____

Insurance Company, MA#, etc._____

Name of individual carrying the policy:_____

Insurance Policy Number:

(Please print legibly)

I,_____ the parent/guardian (circle relationship type) give permission for _____ (name of child) to attend Camp Victory and hereby authorize Camp Victory staff to administer or seek appropriate emergency care as needed. This includes administering "over the counter" medications, under the standing orders of the camp physician. I understand that every effort will be made to contact me should an emergency situation arise.

Signed_____ **Date**_____

Additional Medication

Medication Name____Amount (mg.)______________________
Does medication require refrigeration? ☐Yes ☐No
Times given or as needed (reason)____

Medication Name____Amount (mg.)______________________
Does medication require refrigeration? ☐Yes ☐No
Times given or as needed (reason)____

Medication Name____Amount (mg.)______________________
Does medication require refrigeration? ☐Yes ☐No
Times given or as needed (reason)____

Medication Name____Amount (mg.)______________________
Does medication require refrigeration? ☐Yes ☐No
Times given or as needed (reason)____

Medication Name____Amount (mg.)______________________
Does medication require refrigeration? ☐Yes ☐No
Times given or as needed (reason)____

Medication Name____Amount (mg.)______________________
Does medication require refrigeration? ☐Yes ☐No
Times given or as needed (reason)____