



Sunshine Kids' Club Summer Camp

2010 G.L.P. Sunshine Kids' Club Personal Camp Health Medical Record

Child #1 Information:

Child: _____

D.O.B. _____

***Tetanus: THIS MUST BE PROVIDED TO ATTEND CAMP AND MUST BE CURRENT.**

Date of last immunization: _____

Copy of Insurance card attached _____

Immunizations: Is the camper enrolled in a public or private Maryland school?

YES, PROVIDE NAME OF SCHOOL

Other Medical Issues: Please list any significant medical problems (noting allergies) including symptoms, type of treatment (medicines*, frequency of treatment, complications/side effects) frequency and duration of symptoms & treatments. This would include any condition that would require the administration of medicine* of any type, such as psychological and behavioral conditions, dietary needs, allergies, or special needs.

Pediatrician

Name: _____

Phone# _____

Dentist: _____

Phone: _____

Child #2 Information:

Child: _____

D.O.B. _____

***Tetanus: THIS MUST BE PROVIDED TO ATTEND CAMP AND MUST BE CURRENT.**

Date of last immunization: _____

Copy of Insurance card attached _____

Immunizations: Is the camper enrolled in a public or private Maryland school?

YES, PROVIDE NAME OF SCHOOL

Other Medical Issues: Please list any significant medical problems (noting allergies) including symptoms, type of treatment (medicines*, frequency of treatment, complications/side effects) frequency and duration of symptoms & treatments. This would include any condition that would require the administration of medicine* of any type, such as psychological and behavioral conditions, dietary needs, allergies, or special needs.

Pediatrician

Name: _____

Phone# _____

Dentist: _____

Phone: _____

Child #3 Information:

Child: _____

D.O.B. _____

***Tetanus: THIS MUST BE PROVIDED TO ATTEND CAMP AND MUST BE CURRENT.**

Date of last immunization: _____

Copy of Insurance card attached _____

Immunizations: Is the camper enrolled in a public or private Maryland school?

YES, PROVIDE NAME OF SCHOOL

Other Medical Issues: Please list any significant medical problems (noting allergies) including symptoms, type of treatment (medicines*, frequency of treatment, complications/side effects) frequency and duration of symptoms & treatments. This would include any condition that would require the administration of medicine* of any type, such as psychological and behavioral conditions, dietary needs, allergies, or special needs.

Pediatrician

Name: _____

Phone# _____

Dentist: _____

Phone: _____

***All medicine must be delivered in the original container bearing a pharmacy label which shows the prescription number, date filled, prescribing doctor's name, name of medicine, directions for taking, and patient's name, age, weight and grade. Per the State Department of Health and Mental Hygiene regulations and the MD Board of Nursing, no prescription or non prescription medication can be given at the camp without a physician's order. Also, campers who self-administer medications must have a prescriptive order from a physician. NO EXCEPTIONS! This is in compliance with the COMAR regulation 10.16.06.33 All medicine must be delivered prior to camp starting, directly to the Camp office with all of the pertinent information. A medication order form must accompany all medication entering the camp. Please contact the camp to receive this form should you need one. Thank you.**

Parent/Legal Guardian Name: _____ Emergency #: _____

Address: _____

Name of Health Insurance Carrier: _____ Policy# _____ Member# _____