Camper Medication/Medical Information Form
Form must be completed and signed by camper’s physician.

Information given in this form must be accurate and up to date in order for Camp Echoing Hills to provide adequate care for the individual attending.

- All Prescription Medications must be brought in the original pharmacy container. This includes any daily over-the-counter medications, vitamins, herbal or homeopathic treatments. Inhalers, liquids, or creams must also be in the original container.
- Please provide only enough medications for the duration of the camp event. Medications must match the medication list.
- A current M.A.R. or CURRENT MEDICATION LIST (current to the day the Camper arrives at Camp) must accompany all medications that are checked in at registration.
- All medications (including over the counter pills and treatments) must be checked in with Health Care Staff upon registration.

If your camper does not arrive with all listed medications or without medications in pharmacy labeled containers they will not finish registration or be admitted into the camp week.

Caregiver Checklist: Preparing for the camp event.
- Are all camper medications in pharmacy labeled packaging? (i.e. pill bottles, blister packs, med sachets/rolls)
- Do packed meds match the medications listed by the physician?
- Is the current medication list or M.A.R. with the medications?
- Are the medications separated from camper luggage to be checked in at registration?
- Are treatments and PRN medications listed on the medication list? Are they being sent to camp?
**MEDICATION INFORMATION**

Camper’s Name______________________________________  Age________

Week of Camp/Event____________________________________  Date________

Guardian Name__________________________________________

**MEDICATION**

*PLEASE COMPLETE ALL INFORMATION AND PRINT CLEARLY*

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<tr>
<th>MEDICATION LIST</th>
<th>REASON</th>
<th>DOSAGE</th>
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<th>12:00P</th>
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<th>PRN MEDICATIONS</th>
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Emergency Contact: _____________________  Phone: ________________________________

-- CONTINUED ON BACK --
Medical Diagnosis: ________________________________________________________________

Disability: _________________________________________________________________
Hard of Hearing: _______ Blind: _______ Deaf: _______

Medication Administration – How do they take their Medication?

Whole or Crushed: _______ With (Please Circle) – Water  Pudding  Applesauce  Juice

Liquid Consistency: _______________________  Food Consistency: ______________________

Emergency Medications: __________________________________________________________

Allergies: (Medication, Food, Other) __________________________________________________

Epi-Pen:  Yes   No
Can they use Acetaminopren?  Yes   No
Diabetic:  Yes   No   Insulin: ________________________________________________________

HEALTH HISTORY
Date of last physical exam _______________________

Findings________________________________________________________________________

CAMPER IS FIT TO ATTEND CAMP: YES_____  NO _____ Please note: Camp Echoing Hills is not a medical facility. Our camp has hilly and uneven terrain. Campers will be going up and down hills, out in the sun and heat for long periods and will be sharing a living space with up to 24 other people.

Date of last MEASLES, MUMPS, RUEBELLA vaccination (shot) ______________________

Date of last Tetanus vaccination ___________________________________________________

Any surgeries or serious injuries (dates) _____________________________________________

Chronic or recurring illnesses: ____________________________________________________

HEART OR CIRCULATORY CONDITIONS: Please explain any heart or circulatory conditions, or any history of the same: __________________________________________________________

Please describe any activity restrictions (walking up hills, etc..) ______________________

GENERAL ACTIVITY RESTRICTIONS (please list any restrictions that should be followed while applicant is at Camp.)

________________________________________________________________________________

________________________________________________________________________________

Physician Name (Please Print) ___________________________ Phone Number __________________

Address: ________________________________________________________________

Physician Signature________________________ Date: ______________________