EDINBORO UNIVERSITY MEDICATION TRACKER FORM

Camper's Name: ____ **Date of Birth:** _________________

Allergies: ____

I give permission for a representative to give the following medicines to my child at camp.
Parent/Guardian Signature:____ **Date:** ________________

Medication Name:________________________ Rx: □ Yes □ No
Prescribing Physician: ___________________ Date Filled: ________
Dosage: ______________ Amount in Bottle: _________________
Routine: □ PO □ IM □ SC □ SL □ Topical □ Inhalation □ Rectal
Times: □ PRN □ Daily □ BID □ TID □ QID □ AC □ PC □ HS
Comments: ____
Special Instructions: _________________________________

Med Time	**S**	**M**	**T**	**W**	**R**	**F**	**S**

Medication Name:________________________ Rx: □ Yes □ No
Prescribing Physician: ___________________ Date Filled: ________
Dosage: ______________ Amount in Bottle: _________________
Routine: □ PO □ IM □ SC □ SL □ Topical □ Inhalation □ Rectal
Times: □ PRN □ Daily □ BID □ TID □ QID □ AC □ PC □ HS
Comments: ____
Special Instructions: _________________________________

Med Time	**S**	**M**	**T**	**W**	**R**	**F**	**S**

Medication Name:________________________ Rx: □ Yes □ No
Prescribing Physician: ___________________ Date Filled: ________
Dosage: ______________ Amount in Bottle: _________________
Routine: □ PO □ IM □ SC □ SL □ Topical □ Inhalation □ Rectal
Times: □ PRN □ Daily □ BID □ TID □ QID □ AC □ PC □ HS
Comments: ____
Special Instructions: _________________________________

Med Time	**S**	**M**	**T**	**W**	**R**	**F**	**S**

Medication Name:________________________ Rx: □ Yes □ No
Prescribing Physician: ___________________ Date Filled: ________
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Times: □ PRN □ Daily □ BID □ TID □ QID □ AC □ PC □ HS
Comments: ____
Special Instructions: _________________________________

Med Time	**S**	**M**	**T**	**W**	**R**	**F**	**S**

Medication Name:________________________ Rx: □ Yes □ No
Prescribing Physician: ___________________ Date Filled: ________
Dosage: ______________ Amount in Bottle: _________________
Routine: □ PO □ IM □ SC □ SL □ Topical □ Inhalation □ Rectal
Times: □ PRN □ Daily □ BID □ TID □ QID □ AC □ PC □ HS
Comments: ____
Special Instructions: _________________________________

Med Time	**S**	**M**	**T**	**W**	**R**	**F**	**S**

PO=by mouth IM=intermuscular SC=sub-cutaneous SL=sub-lingual-under-tongue PRN=as needed
BID=two times a day TID=three times a day QID=four times a day AC=before meals PC=after meals HS=at bedtime

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Initial	**Signature**	**Name**	**Position**

Representative Instructions: Sheet is for reproduction as needed. It should be three-hole punched and kept in a binder during camp week. Use one sheet for each camper with a prescription. Record all medicines brought to camp (up to FIVE medications per sheet). The medication, dosage, and dosage schedule should be copied from the prescription. Record dispensing times and days in the blocks provided for each medication as they are dispensed. After camp, place sheet(s) inside the first aid log.

EDINBORO UNIVERSITY SUMMER CAMP MEDICAL HISTORY AND CONSENT FORM

Please print in ink

Camper's Name _____ Date of Birth_____

Street Address_____Phone(_____)_____

City_____ State_____ Zip Code_____

Name of Camp_____ Date of Camp_____

PARENT OR GUARDIAN

Name_____Cell Number (____)_____Work Number(____)_____

Street Address _____City _____State _____Zip Code_____

MEDICAL INSURANCE INFORMATION

Insurance Company Name_____

Insurance Company Address_____

Policy Number _____ Agreement Number _____

Policy Holder Name _____ Relationship to Camper _____

I, the guardian, have medical insurance coverage for my son/daughter and understand that I am responsible for all medical costs associated with injuries, infections, accidents and illnesses that may occur at camp.

EMERGENCY PHONE NUMBERS

1st Choice Name_____ Cell #(_____)_____ Other # (_____)_____

2nd Choice Name_____ Cell #(_____)_____ Other # (_____)_____

MEDICAL HISTORY OF CAMPER

1. Any current medical problems? NO YES
   If yes, _____
2. Had any recent injury requiring medical attention? NO YES
   If yes, _____
3. Currently taking medication? NO YES
   Please list_____
4. Had any severe head or neck injuries? NO YES
5. Had any major surgical operations? NO YES
6. Had any chronic illness (epilepsy, diabetes, heart disease)? NO YES
   If yes, _____
7. Any allergies to prescription and/or non prescriptions medication? NO YES
   Please list_____ Reaction _____
8. Any additional allergies (food, insect, etc.) NO YES
   Please list_____

Please explain any yes answers_____

_____

Date of last tetanus Immunization_____ Name and telephone of Medical Provider_____

I, the guardian, have medical insurance coverage for my son/daughter and understand that I am responsible for all medical costs associated with injuries, infections, accidents and illnesses that may occur at camp.

PARENTAL CONSENT TO MEDICAL TREATMENT

PLEASE SIGN the following statement concerning the medical treatment of my child:

_____In the event of any illness or injury to my child I give the medical provider permission to administer treatment, while continuing to contact the parent, guardian or designated individual.

Informed Consent Release and Express Assumption of Risk

Camp/Clinic Recreational Activities

Edinboro University of PA

I realize injuries can be a consequence of participation in **summer camp recreational activities** and no amount of reasonable supervision or use of the facility will prevent injury. I appreciate the character of the risk involved, and I voluntarily assume all risk of possible death, harm or injury. I understand and appreciate that **summer camp recreational activities** and physical activity involving rigorous exertions and is inherently subject to a risk of substantial physical injury and even death from some actions.

In accepting this risk, I expressly and explicitly release, discharge and waive any and all responsibility of Edinboro University of Pennsylvania, Edinboro University Foundation, the Pennsylvania State System of Higher Education, the Commonwealth of Pennsylvania, and the employees, officials or agents of any and all of the foregoing, pursuant to, or pertaining or related to, or arising from, in any matter, injuries to me as a result of my participation in this activity.

By my signature below, I certify that I completely understand this document.

Participant Printed Name	Participant Signature	Date
Parent/Guardian Printed Name	Parent/Guardian Signature	Date
Witness Printed Name	Witness Signature	Date

INSURANCE & PHYSICAL ACTIVITY FORM

Camp/Clinic Recreational Activities

I _____ have had a recent physical examination and am physically able to participate in **summer camp recreational activities**. I know I am responsible for my own medical expenses if I am injured during this activity.

In the event of illness or injury resulting or arising directly or indirectly out of said activity, I hereby give my consent and authorization for (1) administration of emergency first aid care and treatment at the scene of the emergency by faculty, staff members, or volunteers of the UNIVERSITY or (2) the administration of any treatment deemed necessary by a licensed physician or dentist and (3) the transfer to any hospital reasonably accessible. The authorization is not intended to cover major surgery unless the medical opinions of two (2) licensed physicians or dentists, concurring in the necessity for such surgery are obtained prior to the performance of such surgery. I further declare and warrant that I am covered by sufficient medical and dental insurance and that such insurance will remain in effect during my child's participation in said activity.

_____	_____	_____
Participant Printed Name	Participant Signature	Date
_____	_____	_____
Parent/Guardian Printed Name	Parent/Guardian Signature	Date

EMERGENCY CONTACT INFORMATION

If there is an emergency, please contact:

NAME	RELATIONSHIP	PHONE NUMBER
_____	_____	_____
_____	_____	_____