

**SIXTH GRADE CAMPER PERMISSION AND EMERGENCY
INFORMATION**

Student's Name _____
Last First

Date of Birth _____ Age _____ Teacher _____

Child resides with: Both parents _____ Mother _____ Father _____ Other _____

Parents or legal guardian names _____

Complete Address _____

Home Phone _____

Father's Work Phone _____ Cell/Pager Number _____

Mother's Work Phone _____ Cell/Pager Number _____

Emergency Contact (in case parent/guardian can not be reached)

Name _____ Relationship _____

Home Phone _____ Cell/Pager Number _____

Student's Physician _____

Office Phone _____ Exchange _____

Student's Dentist _____

Office Phone _____ Exchange _____

Health Insurance _____ Phone Number _____

Policy Holder Name _____

Policy # _____ Group # _____

If you have no insurance, please check _____

The following medications are available at TLC by standing orders and may be administered by the camp nurse in order to relieve minor pains and discomforts. Please check the medications that **you will allow** to be administered to your child while at camp.

Saline eye solution _____ Cough drops _____

Hydrocortisone Cream _____ Honey _____

Acetaminophen/Tylenol _____ Benadryl _____

Chloraseptic throat spray _____ Caladryl _____

I hereby authorize a member of the resident administrative staff to transport my son/daughter _____ to the hospital and to hospitalize him/her for emergency treatment if such action is deemed necessary in the judgment of the person in charge. Furthermore, I hereby authorize the physician or physicians to carry out any diagnostic procedure or emergency care pertinent to the immediate injury or illness that is deemed imperative in the treatment of my child.

Signature of Parent or Guardian

Date

**PARKWAY 6th GRADE OUTDOOR EDUCATION
CONFIDENTIAL STUDENT HEALTH INFORMATION**

Student's Name _____

Please check if the following information is applicable.

1. Asthma/allergies which might affect your child. Yes____ No____
If so, what _____
2. Unusual susceptibility to poison ivy? Yes____ No____
3. Exact date of last diphtheria/tetanus (DT) vaccine or Tdap. _____
month/day/year

This information is available through the parent portal in Infinite Campus

4. Is the physical activity of your child restricted by physicians order? Yes____ No____

If yes, the physician's order is required

Other information that will help us to meet the needs of your child: past surgeries, seizure disorder, diabetes, ear or eye problems, heart conditions, orthopedic conditions, specialized health care needs, dietary requirements.

5. Has your child attended a resident camp before? Yes____ No____
Has your child spent the night away from home? Yes____ No____
Car Sickness Yes____ No____
Sleepwalker? Yes____ No____
Bed Wetter? Yes____ No____

6. Will you be sending prescription or OTC medications? Yes____ No____
If yes, please read the attached information regarding medication to be administered at camp. Physician and parent authorization forms are available from the school nurse.

What prescription medication will you be sending? (must be in current pharmacy container)

What over-the-counter medicine? (must be accompanied by physicians note)

**PLEASE SEE SCHOOL NURSE FOR SPECIFICS ON MEDICATION
ADMINISTRATION WHILE AT CAMP**