

Covenant Kids Summer Camp 2010
Covenant Classical Christian School
Over-the-Counter Medication Consent/Authorization for Emergency Medical Treatment

Camper's Name _____ Grade Completed _____

Birthdate _____ Age _____ Height _____ Weight _____

COVENANT CLASSICAL CHRISTIAN SCHOOL SUMMER CAMP DOES NOT EMPLOY A NURSE.

The following over-the-counter medication is offered to campers:

- Acetaminophen (non-aspirin pain reliever/regular strength)
- Ibuprofen (200 mg. tablets)
- Antacids
- Throat Lozenges
- Liquid antihistamine for acute allergic reactions such as hives (e.g. Benadryl)
- First-aid care including, but not limited to:
 - Antiseptic wash
 - Antibiotic ointment (e.g. Neosporin)
 - Antihistamine cream for insect bites (e.g. Benadryl cream)

_____ YES, I authorize camp personnel to administer all medications listed above to my camper.

_____ LIMITED, I authorize camp personnel to administer the medications listed above to my camper **with the exception of the medications crossed through.**

_____ NO, I prefer that my camper receive no medication from camp personnel.

List any allergies to food, insect stings, medication, etc., chronic health conditions, current prescriptions and any recent major illness/injury/operation. **Provide an emergency kit, inhaler, or EpiPen if your camper has a life-threatening allergy or asthma.**

I give permission for my camper to participate in all on and off-campus activities and absolve the camp from liability to me and my camper due to any injury to my camper during a camp activity. In the event of an accident, I authorize Covenant Classical Christian School Summer Camp and its designated representatives to consent, on my behalf, to any medical/hospital care or treatment to be rendered upon the advice of any licensed physician. If such an event occurs, I understand that every effort will be made to contact me as soon as possible. I agree to be responsible for all necessary charges incurred by any hospitalization or treatment rendered pursuant to this authorization.

Signature of Parent or Legal Guardian

Date

Health Insurance Company _____

Address _____

Phone _____ Pre-certification Phone No. _____

Policy No. _____ Insured's Name _____

Hospital of Choice _____

Physician's Name _____ Phone _____