

**First Aid/Medication Authorization Form
(Prescribed Medications)**

Childs full name: _____ Age: _____ DOB _____

Name of Current Medications: _____

Prescription No.: _____ Prescription Date: _____

Quantity # daily: Am: _____ Noon: _____ Pm: _____

I, _____, grant permission designee to assist in the administration of prescribes medications for my child, _____.

I certify that the prescribed medication is in its original container and that it is necessary, according to my Doctor's instructions, for this medication to be provided. I understand that this medication will be given only according to the directions on the label as prescribed by the Doctor. I further understand that at the end of the camp it will be my responsibility to pick-up any unused medication within one week after camper has gone, if said medication has not been retrieved by this time we will properly dispose of medication for the safety of the other campers.

**First Aid/Medication Authorization Form
(Over the Counter Medication/Topical)**

This form is valid for **Diamond D Ranch; Summer Horse Camp program 2010** this form must be renewed every year. The following items will be administered in the correct dosage for your child's age and weight in the event of minor injuries, scrapes, etc. If your child is allergic to any of the medications and/or the ones listed below **in any form**, please write **NO** if child can not be administered or **YES** if they can be administered, from the list below.

- | | | |
|---------------------|---|----------------------------------|
| _____ Tylenol | _____ Benadryl | _____ Triple Antibiotic Ointment |
| _____ Motrin | _____ Rubbing Alcohol | _____ Sun Screen |
| _____ Acetaminophen | _____ Iodine Tincture/Mercurochrome | _____ Band-Aids |
| _____ Imodium AD | _____ Calamine Lotion | |
| _____ Pepto Bismol | _____ Over the counter insect/burn medicine | |

_____ Parent initial here if it is acceptable to give any of the above listed marked yes medication/topical.

Health History

Check if camper is allergic to the following:

Allergies _____ (Specify) _____

Asthma _____ Fainting/Convulsions _____ Heart Trouble _____ Tubes in ears _____ Diabetes _____

Severe Reactions to bee stings _____ Common Reaction _____

Immunization Date: Tetanus _____ Polio _____ Measles/mumps/rubella (3 day measles) _____

Any current condition requiring medication? Yes ___ No ___ (please use a separate sheet of paper if needed for full explanation)

If yes, instruction: _____

Any restrictions of activities for medical reasons? Yes ___ No ___ (please use a separate sheet of paper if needed for full explanation)

If yes, what are the restrictions? _____

Do you carry Family Health Insurance? Yes ___ No ___ Carrier: _____ Group # _____

Family Doctor: _____ Phone: (____) _____

Family Dentist/Orthodontist: _____ Phone: (____) _____

Is there anything you want your child's counselor to be aware of? I.e. Changes in family life, learning disabilities, phobias?

Parent's Note and/or Explanations: _____

Date Signature of Parent/Legal Guardian Print Name

Day Time Emergency Contact Number Emergency Contact Name

Day Time Emergency Contact Number Emergency Contact Name