ANC

ACADEMY OF THE NEW CHURCH
SECONDARY SCHOOLS

ANC SUMMER CAMP HEALTH FORM

Please fill out this form and return to:

ANC Summer Camp
Crystal Smith BSN, RN, CSN
Doering Health Clinic
Box 710, Bryn Athyn, PA 19009

Camper's Name: ________________ Date of Birth: ____/____/____ (Month / Day / Year) Gender: ❑ Male ❑ Female

Address: ________________________________
Street/P.O. Box/Apt. No.

____
City State/Province Zip/Postal Code Country

Parents' Contact Information: ***(circle which is BEST)***

Home: ________________________________

Father - Cell: __________ Work: __________ Email: __________

Mother - Cell: __________ Work: __________ Email: __________

1.) Hospitalization insurance name and policy number: (this is a requirement to attend camp)

Name of Company: __________ Policy #: __________ Group #: __________ Phone: __________

***Please include a copy of the front and back of your insurance card.**

2.) Medical information: *(please check and fill in blanks)*

Does the camper have any **allergies?** ❑ Yes ❑ No To what? __________

Does the camper have asthma? ❑ Yes ❑ No What kind? (severe, mild, exercise induced) __________

If you answered yes to the previous question, please include an Asthma Action Plan.

Any other illness we should know about? ❑ Yes ❑ No Please describe: __________

Do you anticipate your child needing extra support for any reason? ❑ Yes ❑ No If yes, please describe: __________

____

If you would prefer to speak in person, feel free to call Crystal Smith: 267-502-4582

3.) Immunization Records

Please provide a **current copy of immunization records** if your child does not attend ANCSS.

4.) Rules about medication:

All prescription medication must be reviewed with the nurse prior to the start of camp and must be administered by the nurse during the week of camp. Please supply medications to the nurse at check in. **Parents must provide written permission and a physician's order for prescription medicine, and the medicine must be provided in a properly labeled pharmacy bottle. (see page 3).**

No camper may have any prescription or over-the-counter medicine in their posession. All medications must be kept at the Doering Health Clinic. Failture to comply with this may be grounds for dismissal.

Medical care will be initiated in consultation with parents/guardians. The law requires that parental permission be obtained for medical/surgical procedures. However, in case of an emergency when the parents/guardians cannot be reached immediately, we ask that the following consent form be signed so that there is no unnecessary delay in treatment.

In the event that I cannot be reached in a timely manner, I give consent for the Director of the Doering Clinic or designated staff member to give permission for diagnostic procedures, medical or minor surgical treatment deemed necessary for my child while at camp.

Signature: ________________ Relationship: __________ Date: __________

PERMISSION FOR ADMINISTRATION OF NON-PRESCRIPTION MEDICINE:

Below are the medications available to campers administered by the camp nurse. Please review carefully and check yes or no for your child.

Camper Name: ______________________________ **Date of Birth:** ______________

Medications:

YES	NO	
❏	❏	1. Acetaminophen: two tablets of 325mg strength as needed for pain. a. May repeat every 4-6 hours, not to exceed 6 tabs in 24 hours.
❏	❏	2. Ibuprofen: two tablets of 200 mg strength as needed for pain. a. May repeat every 4 hours.
❏	❏	3. Sudafed or generic equivalent: two 30 mg tabs as needed for congestion. a. May repeat every 4-6 hours, not to exceed 6 tabs in 24 hours. b. or "Sudanyl PE" (phenylephrine) 5 mg. one or two tablets for sinus congestion per package
❏	❏	4. Loratadine 10mg: One tablet daily as needed for cold/allergy symptoms per directions on package.
❏	❏	5. Cough Drops
❏	❏	6. Tums chewable: two tablets for indigestion, repeat as directed by manufacturer.
❏	❏	7. Immodium or generic equivalent loperamide HCL: 2 mg caplets as needed for diarrhea. a. Two caplets after first loose stool, then one caplet after subsequent loose stools, not to exceed 4 in 24 hours.
❏	❏	8. Miralax 17g dissolving: Once a day according to package directions for constipation.
❏	❏	9. Homeopathic remedies as prescribed by student's homeopathic practitioner.
❏	❏	10. Benadryl or generic equivalent: 25mg to 50 mg capsules or liquid as needed for allergic reaction, itching from poison ivy or swelling from bee sting.
❏	❏	11. Epi-Pen auto injector: 0.3 mg as needed for acute allergic reaction. a. Administered only in acute allergic response evidenced by signs of impending anaphylaxis or self-report of ingestion of life-threatening allergens.

Authorization:

- I understand that **no medications** may be kept with my child. Compliance with this honors the laws, nursing licenses, and protects the entire campus.
- I have reviewed these Standing Orders. Permission is granted for the Director of Student Health Services or designee to provide these medications for my son/daughter for minor illness or discomfort.
- I have checked and specified "Do Not Give" on any medications that I do not want my child to have.
- I hereby release and hold harmless the Academy of the New Church, its employees, directors, agents, and assigns from any liability, claims, demands, actions and/or attorneys' fees from the administration of medication to the above noted camper in accordance with this form.

Signature: ______________________________ Date: ______________

Print Name: ______________________________ Relationship: ______________

AUTHORIZATION AND RELEASE FOR ADMINISTRATION OF PRESCRIPTION MEDICATIONS

Please complete the following information, then date and sign this form. Your signature confirms your authorization for the nurse to administer medication. Time and dose must be accurate and current and must match the pharmacy label. **Campers are not permitted by law to have prescription medications in their possesion.**

Parents must provide written permission and a physician's order for prescription medicine, and the medicine must be provided in a properly labeled pharmacy bottle.

Name of Camper: ____

Name of Medicine: ______________________ Dose: ____________ Time: __________

Name of Medicine: ______________________ Dose: ____________ Time: __________

Name of Medicine: ______________________ Dose: ____________ Time: __________

Name of Medicine: ______________________ Dose: ____________ Time: __________

(Continue on back if needed)

Parent or Personal Representative Signature: ______________________ Date: __________

Release:

I hereby release and hold harmless the Academy of the New Church, its employees, directors, agents, and assigns from any liability, claims, demands, actions and/or attorneys' fees from the administration of medication to the above noted camper in accordance with this form.

Parent or Designee Signature: ______________________________ Date: __________

Nurse Signature: ______________________________________ Date: __________

Continue

CONSENT AND BLANKET WAIVER

Please sign the Consent and Indemnification Agreement

We/I____

and____,

parent(s)of____,

Who is attending the ANC Summer camp hereby consent to our child having access to the internet.

We/I understand that our/my child is responsible for their activities on the internet, and we/I specifically agree, indemnify and hold the Academy harmless for any damage to or loss caused by our/my child's activities on the internet and further agree to reimburse the Academy for the damage.

Signature: ________________________________ Date: ______________

Waiver:

You must have your parents sign the following waiver for all activities (course and recreation) for the ANC Summer camp.

I/we agree to indemnify and to save harmless the Academy of the New Church, its officers, employees and agents from any loss, suit, claim or damage during the ANC Summer camp.

Camper Name: ____

Please Print

Parent or Guardian: ____

Please Print

Parent or Guardian Signature: ________________________________ Date: ______________

Medication Consent:

We/I agree to abide by the Academy of the New Church's Medication Policy. We/I will not provide any medication for our/my child to keep in their dorm room.

Parent or Guardian: ____

Please Print

Parent or Guardian Signature: ________________________________ Date: ______________