



MEDICAL ALERT FORM

DO NOT MAIL ~ PLEASE BRING COMPLETED FORM TO FIRST DAY OF CAMP

We are so excited to have your child join us for a week of hands on science. To ensure the health, safety and success of your child while at camp, please complete this form & bring to camp on first day.

Check week(s) at camp:

- 6/04-6/08 6/11-6/15 6/18-6/22 6/25-6/29 7/02-7/06* 7/09-7/13
- 7/16-7/20 7/23-7/27 7/30-8/03 8/06-8/10 8/13-8/17 8/20-8/24

CHILD'S NAME: _____ SITE: _____

PARENT/GUARDIAN: _____ CELL: _____

OTHER EMERGENCY CONTACT: _____ CELL: _____

Will your child be on prescription medication during these weeks? Yes No

I understand that all medication must be provided daily in original pharmacy packaging with the child's name & dispensing instructions on the label. I hereby authorize Destination Science to assist my child in taking their prescribed medication -OR- My child may self-administer his/her own medication (older children).

Medication: _____ Location of Med(s): _____

Instructions/Dosage: _____ Time(s) of Day: _____

Day/Date	Dosage	Time	Staff Person	Day/Date	Dosage	Time	Staff Person
Monday:				Thursday:			
Tuesday:				Friday:			
Wednesday:							

HEALTH INFORMATION:

Does your child have a need to use a rescue inhaler during camp? Yes No

List Allergies _____

- High Risk for Severe Reaction? Yes No Possibly

Symptoms: Difficulty in breathing Swelling of face/lips Hives Vomiting
Other (explain): _____

Action Plan for Reaction: _____

Does your child carry an EpiPen? No Yes, please show staff the location of EpiPen.

Does your camper have any **restrictions or adaptations** that would prevent him/her from participating at camp?
 No Yes, Comments:

List any **medical, physical, emotional, behavioral or social conditions** that may affect your camper's experience while on-site:

Action Plan: _____

Parent/Guardian Authorization--This information is correct and the child described has permission to participate in all camp activities except as noted on this form. I understand that the camp has limited healthcare on site and that staff will call the indicated parent/guardian (a) in an emergency, (b) if questions about my child's health may arise, and/or (c) when my child is unable to continue because of injury or illness. I acknowledge that the program will handle medication as described and that information on this form will be shared with staff on a need-to-know basis

Parent / Guardian Signature: _____ Date: _____

DESTINATION SCIENCE

A nonprofit organization dedicated to getting kids excited about science & building great life skills. ID# 33-0943159

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