

**JT LOCKE SUMMER CAMP  
MEDICAL INFORMATION FORM**

**NO CAMPER WILL BE PERMITTED TO ENTER CAMP WITHOUT THIS MEDICAL FORM**

DATE: \_\_\_\_\_

CAMPER'S NAME: \_\_\_\_\_ CAMPER'S DATE OF BIRTH: \_\_\_\_\_

CAMPER'S ADDRESS: \_\_\_\_\_

GUARDIAN'S NAME: \_\_\_\_\_ TELEPHONE: (H) \_\_\_\_\_ (W) \_\_\_\_\_

IF UNABLE TO CONTACT ABOVE PARENT/GUARDIAN, PLEASE NOTIFY:

NAME: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

OR

NAME: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

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IS YOUR CHILD EXEMPT FROM IMMUNIZATIONS BECAUSE OF RELIGIOUS OR MEDICAL REASONS?  YES  NO

THE EXAMINATION OF \_\_\_\_\_ WAS WITHIN NORMAL LIMITS WITH THE FOLLOWING EXCEPTIONS:

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IMMUNIZATIONS HAVE BEEN COMPLETED:  YES  NO

DATE OF MOST RECENT TETANUS BOOSTER: \_\_\_\_\_

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ALLERGIES: \_\_\_\_\_

MEDICATIONS/NAME/DOSE/WHEN TAKEN: \_\_\_\_\_

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OTHER MEDICAL CONCERNS: \_\_\_\_\_

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LIMITATIONS TO ACTIVITY: \_\_\_\_\_

**Primary Health Care Provider Information**

Printed Name: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

HEALTH INSURANCE COMPANY:

\_\_\_\_\_

**JT LOCKE SUMMER CAMP**  
**PARENTAL CONSENT FORM**

**NO CAMPER WILL BE PERMITTED TO ENTER CAMP WITHOUT THIS MEDICAL FORM**

**DEAR PARENTS OF CHILDREN IN THE JT LOCKE SUMMER CAMP PROGRAM:**

**THE FOLLOWING IS A PARENTAL CONSENT PERMIT FROM THE JT LOCKE SUMMER CAMP PROGRAM. THIS CONSENT FORM IS TO BE FILLED OUT BY THE PARENT/GUARDIAN TO BE USED IF ANY MEDICAL ATTENTION IS NEEDED FOR YOUR CHILD DURING HIS/HER PARTICIPATION IN THE JT LOCKE SUMMER CAMP. WE WOULD APPRECIATE YOUR SIGNING AFTER CAREFUL READING.**

**SINCERELY,  
STEPHANIE BARBEE  
EXECUTIVE DIRECTOR**

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**PARENTAL CONSENT FOR MEDICAL TREATMENT**

**THE LAW REQUIRES THAT PARENTAL PERMISSION BE OBTAINED FOR MEDICAL PROCEDURES ON MINORS. THE FOLLOWING CONSENT FORM SHOULD BE SIGNED BY PARENTS/GUARDIANS SO THAT SUCH PROCEDURES MAY BE CARRIED OUT WITHOUT DELAYS. HOWEVER, NO MAJOR MEDICAL PROCEDURES WILL BE PERFORMED, EXCEPT IN EXTREME EMERGENCY, WITHOUT PARENTS OR GUARDIANS BEING CONTACTED AND FULLY INFORMED.**

**I GIVE PERMISSION FOR SUCH DIAGNOSTIC/THERAPEUTIC PROCEDURES AS MAY BE DEEMED NECESSARY FOR MY CHILD, AND TO PRESENT INFORMATION CONCERNING HIS/HER MEDICAL CONDITION TO OTHER RESPONSIBLE UNIVERSITY OFFICIALS WHEN REQUESTED.**

**CHILD'S NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**PARENT/GUARDIAN'S NAME:** \_\_\_\_\_

**PARENT/GUARDIAN SIGNATURE:** \_\_\_\_\_

**RELATIONSHIP TO CAMPER:** \_\_\_\_\_

**IS YOUR CAMPER COVERED BY HEALTH INSURANCE FOR DOCTORS AND HOSPITAL BILLS?** \_\_\_\_\_

**IF "YES" WHAT COMPANY?** \_\_\_\_\_

**POLICY #** \_\_\_\_\_

**POLICY HOLDER NAME** \_\_\_\_\_

**PLEASE NAME ALL PERSONS ALLOWED TO PICK UP YOUR CHILD:**

_____	_____
_____	_____
_____	_____
_____	_____

**JT LOCKE SUMMER CAMP**

**CONSENT FOR ADMINISTRATION OF APPROVED MEDICATIONS**

**NO CAMPER WILL BE PERMITTED TO ENTER CAMP WITHOUT THIS MEDICAL FORM**

CAMPER'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

**MEDICATION ALLERGIES/SENSITIVITIES:**

**LIST ANY MEDICATION(S) YOUR CHILD RECEIVES ON A REGULAR BASIS:**

I HEREBY GIVE PERMISSION FOR MY CHILD, \_\_\_\_\_ TO RECEIVE ANY MEDICATION LISTED BELOW ON THIS FORM AS DEEMED NECESSARY. I HAVE CHECKED THOSE MEDICATIONS I WISH TO BE MADE AVAILABLE TO MY CHILD. I UNDERSTAND THAT GENERIC EQUIVALENT MEDICATIONS WILL BE USED IN PLACE OF MORE EXPENSIVE BRAND-NAME ITEM.

PLEASE CHECK ANY MEDICATION YOU WISH TO BE MADE AVAILABLE TO YOUR CHILD:  
FOR

<b>HEADACHE/FEVER/EARACHE/MUSCLE ACHES/PAIN/MENSTRUAL CRAMPS</b>	<b>BITES/STINGS/ALLERGIC RASHES</b>	<b>SORE THROAT</b>
<input type="checkbox"/> ACETAMINOPHEN (LIKE: TYLENOL)	<input type="checkbox"/> ANTI-ITCHING LOTION (LIKE: CALAMINE)	<input type="checkbox"/> THROAT LOZENGES
<input type="checkbox"/> IBUPROFEN (LIKE: ADVIL)	<input type="checkbox"/> ANTI-ITCHING CREAM (LIKE: 1% HYDROCORTISONE)	
	<input type="checkbox"/> TOPICAL ANESTHETIC (LIKE: MEDICAINE)	
<b>UPSET STOMACH</b>	<b>MILD ALLERGIC REACTIONS</b>	<b>COUGHS</b>
<input type="checkbox"/> ANTACID (LIKE: TUMS OR MAALOX)	<input type="checkbox"/> DIPHENHYDRAMINE (LIKE: BENADRYL)	<input type="checkbox"/> COUGH DROPS

I UNDERSTAND THAT THE MEDICATIONS I HAVE CHECKED WILL BE ADMINISTERED BY THE STAFF AT JT LOCKE SUMMER CAMP IN ACCORDANCE WITH THEIR ESTABLISHED PROTOCOLS.

I DO NOT WANT ANY MEDICATION GIVEN TO MY CHILD AT JT LOCKE SUMMER CAMP.

PRINTED NAME OF PARENT/GUARDIAN \_\_\_\_\_

SIGNATURE OF PARENT/GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

HOME TELEPHONE \_\_\_\_\_ WORK/EMERGENCY PHONE \_\_\_\_\_