UNIVERSITY OF CENTRAL ARKANSAS
MEDICAL HISTORY & CONSENT FOR TREATMENT
(REQUIRED)

Camp: _____ Start Date: _____ End Date: _____

Camper: _____ DOB: ____ / ____ / ____ Age: _____

Street Address _____City _____ State _____ Zip _____

Parent/Guardian _____Address _____ State_____

Cell PH# ( ) _____ Work PH# ( ) _____Other PH# ( ) _____

EMERGENCY CONTACT – In case of emergency, if parent/guardian cannot be reached, name of person to notify or to whom we can release camper to in your absence.

NAME _____ Relationship _____PH# ( ) _____

MEDICAL HISTORY:

☑ ALL MEDICAL CONDITONS THAT APPLY

☐Constipation	☐Bed wetting	☐Sleepwalking	☐Ear problems	☐Asthma
☐Seizures	☐Diabetes	☐Bronchitis	☐Frequent colds	☐Sinusitis
☐Nausea	☐Vomiting	☐Eating disorder	☐Heart problems	☐Cancer
☐Kidney problems	☐Homesickness	☐Abdominal problems	☐Menstrual problems	☐Sore throat

☐Other: _____

ALLERGIES:
☐Drug: _____
☐Food: _____
☐Bee Stings
☐Latex

IMMUNIZATIONS: Date of Last Tetanus Injection _____

Describe physical conditions requiring restrictions on participation in camp program: _____

_____

INSURANCE INFORMATION:

NAME OF PCP (PRIMARY CARE PHYSICIAN) _____ PH# ( ) _____

INSURANCE COMPANY _____ MEMBER # _____

POLICYHOLDER (Print) _____ Relationship: _____

PARENT/GUARDIAN SIGNATURE _____Date_____

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MEDICATION CONSENT FORM

If medication consent form is not fully completed, medications will not be administered to the camper.

PRESCRIPTION MEDICATIONS WITH DOSAGE SCHEDULE:

_____
_____
_____

MEDICATIONS CAMPER TAKES AS NEEDED (i.e. Tylenol, Ibuprofen, Midol, Tums, Benadryl, Claritin, Cough medication, Skin creams)

_____
_____

PRESCRIPTION MEDICATIONS:

Arkansas State Law *requires* parental authorization to administer any prescription medications brought by campers. Prescribed medication MUST be in its original container with the pharmacy label showing number, patient name, date filled, and physician name, name of medication and directions for use.

I authorize my child to take his/her own *prescription medications.* ☐Yes ☐No

I authorize the camp health care designee to administer to my child any *prescription medications* brought to camp.
☐Yes ☐No

NON-PRESCRIPTION MEDICINES:

I authorize my child to take his/her own over-the-counter *non-prescription medications*. ☐Yes ☐No

I authorize the camp health care designee to administer the *non-prescription medications* as deemed necessary for the camper's comfort, as listed previously. ☐Yes ☐No

REQUIRED PARENT/GUARDIAN CONSENT FOR TREATMENT

I understand that I am giving consent for my child to receive treatment at the UCA Student Health Clinic by a Healthcare Professional if needed. This medical history/medication consent form is correct as far as I know and I understand that both forms must be filled out COMPLETELY in order for my child to receive treatment at a UCA camp.

I understand that in case of an emergency, every effort will be made to contact a parent or guardian prior to treatment. However, if the parent or guardian cannot be reached and the situation requires immediate emergency attention as determined by the camp staff or by the clinic staff, I hereby authorize representatives of the camp to obtain emergency treatment for my child as deemed necessary.

I AGREE TO THE RELEASE OF ANY RECORDS NECESSARY FOR TREATMENT OR REFERRAL OF THE MINOR CHILD.

PARENT/GAURDIAN SIGNATURE _____Date_____