



# CVP 2010 Medical Profile

Please complete and send to: 554 McCallie Ave, Chattanooga, TN 37402  
 After May 31 send to: 3216 Lee Pike, Soddy Daisy, TN 37379

Last Name \_\_\_\_\_

## CAMPER INFORMATION

|  |        |               |                |
|--|--------|---------------|----------------|
| Camper Name:                           |        | Age:          | Session:       |
| Street Address:                        |        |               | Date of Birth: |
| City:                                  | State: | Zip:          | Home Phone:    |
| Name of Parents or Legal Guardian:     |        | Home #:       | Cell #         |
| Emergency Contact (other than parent): |        | Relationship: | Contact #:     |

First Name \_\_\_\_\_

## CAMPER MEDICAL HISTORY

|   |         |       |
|---|---------|-------|
|   | Reason: | Year: |
| Hospitalizations:                                     |         |       |
| Surgery:  |         |       |
| Previous Bone or Joint Injury:                        |         |       |
| <b>ALLERGIES</b><br><br><input type="checkbox"/> None | Drugs:  |       |
|   | Food:   |       |
|   | Other:  |       |
| Health Problems:                                      |         |       |

M.I. \_\_\_\_\_

Session \_\_\_\_\_

**\*Head Lice Policy:** We will thoroughly check all campers and staff for lice upon arrival. If any nits are found, we will quietly ask the parent to take the child home until he/she can be treated and return to camp nit free.

|  |           |                   |         |
|--|-----------|-------------------|---------|
| <b>CURRENT MEDICATIONS</b><br><br>Does your child know how to use this medication?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | Medicine: | Dosage/how often: | Reason: |
|  |           |                   |         |
|  |           |                   |         |
|  |           |                   |         |

|                          |           |           |
|--------------------------|-----------|-----------|
| Insurance Company:       |           |           |
| Insurance Policy Holder: | DOB:      | Employer: |
| Policy # :               | Group #:  |           |
| Child's Doctor:          | Phone # : |           |

### MEDICATION POLICY

Medication (both prescription and over-the-counter) **MUST** be checked in with the nurse/doctor at the time of registration. ALL MEDICATION, BOTH PRESCRIPTION AND OVER-THE-COUNGER MUST BE BROUGHT IN THE ORIGINAL CONTAINER with camper's name as primary patient. If dosage has changed, a note from the physician will be needed stating new instructions. Please send enough for the entire session, along with a 7-Day pillbox like the one shown. \$2.00 will be deducted from your child's camp store account if pillbox is not provided.

|   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|
| S | M | T | W | T | F | S |
|---|---|---|---|---|---|---|

| IMMUNIZATIONS | Date |
|---------------|------|
| DPT Booster   |      |
| Polio         |      |
| MMR           |      |
| Last Tetanus  |      |

### Over-the-counter Medications (Nurse will administer)

Camper's Height: \_\_\_\_\_  
 Camper's Weight: \_\_\_\_\_

If needed, which of these can your child take:

|                                  |  |   |
|----------------------------------|--|---|
| <input type="checkbox"/> Advil   | <input type="checkbox"/> Acetaminophen | <input type="checkbox"/> Robitussin                 |
| <input type="checkbox"/> Sudafed | <input type="checkbox"/> Benadryl      | <input type="checkbox"/> Decongestant/Antihistamine |