

SCHOOL NAME: _____ Dates coming: _____ Student _____ Cabin Leader _____ Teacher _____

HEARTLAND EMERGENCY MEDICAL AUTHORIZATION AND INFORMATION FORM

First Name: _____ Last Name: _____ Date of Birth: _____ Age: _____ Gender (circle one): M F
 Address: _____ City: _____ State: _____ Zip: _____ Home Phone: _____
 Parent or Legal Guardian(s) Name(s): _____
 Work Phone Number (Dad): _____ Work Phone Number (Mom): _____
 Cell Phone Number (Dad): _____ Cell Phone Number (Mom): _____
 Emergency Contact (If Parent or Guardian cannot be reached) Name: _____ Relation: _____ Phone: _____
 Medical Insurance Company: _____ Policy Number: _____

Heartland provides many generic over-the-counter medications a student might need during their stay at camp. We will provide Tylenol, Advil, Benadryl, Tums. Please do not send over-the-counter medications unless it is something very specific (i.e. Zyrtec, Claritin, etc.)

Due to Federal and State Law ALL medications must have the current prescription label, be in the name of the student taking the medication, and in their original bottle (prescriptions in the prescription bottle, supplements in their original bottle). All medication will be given according to the dosing instructions. If they have changed, we must have a note with the changes and the doctor's signature. We cannot give a medication unless it meets the criteria listed above.

Please list any medications that your child will be taking while at camp. Please send only the amount of medication needed for the camp trip.

Name Of Medication	Dose	Reason for Medication	When Taken
Example: Erythromycin	1 pill, 4 times a day	Asthma	Breakfast, Lunch, Dinner, Bedtime

I give permission for my child to self-carry their emergency medication(s): Yes No (**If yes**, please send a copy of the school's self-carry form)

If you need more room for the medications or health history, please use the back side. Thanks!

Health History (please check if applicable)

Convulsions/Seizures Bedwetting Diabetes
 Bleeding/Clotting disorders Sleepwalking Asthma

Other potential health problems (please list)

Allergies (please check if applicable)

Bee stings Allergies to medication (please list) _____

FOOD ALLERGIES (please list)

FOOD RESTRICTIONS (please list)

REQUIRED FOR EACH YOUTH CAMPER: I HEREBY GIVE PERMISSION TO HEARTLAND, LICENSED BY THE STATE OF OHIO AND MORROW COUNTY, TO SECURE EMERGENCY MEDICAL AND SURGICAL TREATMENT. ALSO TO PROVIDE ROUTINE, NON-SURGICAL MEDICAL CARE FOR THE MINOR CHILD NAMED ABOVE WHILE ATTENDING CAMP. I RELEASE ALL PHOTOS, VIDEO AND AUDIO TAPES OF MY CHILD TO HEARTLAND FOR PROMOTIONAL PURPOSES SUCH AS BROCHURES, VIDEO, WEB PAGES, ETC. I HEREBY GRANT PERMISSION FOR MY CHILD TO PARTICIPATE IN THE ACTIVITIES INCLUDED IN THE OUTDOOR ENVIRONMENTAL EDUCATION EXPERIENCE AND ACCEPT ANY RISKS INVOLVED IN HIS OR HER PARTICIPATION AS WELL AS PERSONAL FINANCIAL RESPONSIBILITY FOR ANY INJURY OR LOSS SUSTAINED DURING THE ACTIVITIES AND HOLD HEARTLAND OUTDOOR ENVIRONMENTAL SCHOOL HARMLESS FOR SUCH INJURY OR LOSS ARISING DIRECTLY OR INDIRECTLY FROM SAID ACTIVITIES.

I certify that this information is true to the best of my knowledge.

Parent or Legal Guardian Signature

Date
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