# Consent to Treatment Linden Hall Summer Camp

Parent or Guardian to complete

_____ _____
Please print camper name Date of Birth

_____ _____ _____
Please print parent/guardian name Relationship to camper Telephone Number

_____ _____ _____
Emergency contact Relationship to camper Telephone Number

_____ _____
Camper's Physician Name Telephone Number of Physician

I authorize Linden Hall staff to administer medications, to hospitalize, and/or secure treatment for my child in the case of medical, surgical, dental, or other emergency illness, injury, or other condition.
The physician, or consultant from whom treatment is secured reserves the right to perform diagnostic laboratory or other tests including radiological exams, and to prescribe treatment and medication according to his/her best judgement and discretion.

I understand that communication from the school will be to the primary custodial parent unless otherwise requested. I understand that all Health Center charges will be charged to my child's account. If medications or supplies are ordered from the local pharmacy, charges will be submitted to my insurance company or credit card by the pharmacy. I understand that I am responsible for all claims and matters related to my insurance company. I understand I will be responsible for all incurred costs of health care regardless of surrounding circumstances or my insurance coverage.
I release Linden Hall from any liability arising from any situation related to the existence of a medical or other condition that was not disclosed to the school.

_____ _____
Parent/Guardian signature Date

| Medical History<br>Please check any that apply and describe in space provided | | |
|---|---|---|
| | Heart/Lung Condition | |
| | Muscle/Bone Condition or history of fracture | |
| | Digestive Condition | |
| | Asthma | |
| | Allergies to food/environmental/medications | |
| | History of concussion | |
| | Migraines/Headaches | |
| | Past surgery | |
| | Eye, ear, nose or throat | |
| | Current medication Please list medication information on sheet provided | |

# Medications

## Linden Hall Summer Camp

Parent or guardian signature required

_____ _____
Please print camper name Date of Birth

_____ _____
Please print parent name Telephone Number

**Medication 1**: _____ Take with food? Y N

Dosage: _____ Route: _____ Time to be taken: _____

**Medication 2**: _____ Take with food? Y N

Dosage: _____ Route: _____ Time to be taken: _____

**Medication 3**: _____ Take with food? Y N

Dosage: _____ Route: _____ Time to be taken: _____

I give permission for Linden Hall Summer Camp staff to administer the above medication(s) to my child. Should a change in the above information occur, I understand that a new authorization must be submitted.

Campers are NOT permitted to keep medication of any kind in their dorm room. All prescription and over-the-counter medication must be turned in upon arrival.

Staff will keep medications in a locked area.

_____ _____
Parent or guardian signature Date

_____ _____
Prescribing physician name Telephone number of physician

# Permission for Over-the-Counter Medications

## Linden Hall Summer Camp

Parent or guardian must complete

_____ _____

Please print camper name Date of Birth

_____ _____ _____

Please print parent/guardian name Relationship to camper Telephone Number

While at camp, it may be necessary for Linden Hall Summer Camp staff to administer over-the-counter medication for symptom relief. Linden Hall Summer Camp staff will have a small supply of the following medications on hand to provide to your child if necessary.

Campers may not keep medication of any kind in their dorm room. All prescription and over-the-counter medication must be turned in upon arrival.

All over-the-counter medication will be administered to your child based on the manufacturer's dosage guidelines.

Please indicate which medications your child may have by answering Yes or No.

Please indicate "Yes" or "No"

| | |
|---|---|
| Yes | Acetaminophen |
| Yes | Antacid (TUMS) |
| Yes | Antihistamine (Generic Benadryl) |
| Yes | Generic Zyrtec |
| Yes | Eye drops |
| Yes | Hydrocortisone Cream |
| Yes | Antibiotic ointment (Generic Neosporin) |
| Yes | Ibuprofen |

_____

Parent or guardian signature

# Covid-19 Vaccination Status

Camper Name _____ DOB _____

Has the camper named above received a Covid-19 vaccination?

☐ Yes

☐ No

If yes, please include a copy of the camper's vaccination card for the school nurse's records.
(You may print this form and place the card in the space below when scanning, or you may attach the copy separately.)

_____ _____

(Parent signature) (Date)