HARBOR LIGHT FELLOWSHIP
CHILDREN'S FELLOWSHIP CAMP AND FAMILY DAY 2023
MEDICAL AND PERMISSION PACKET

The Word of God is the Will of God

> The counsel of the LORD standeth for ever, the thoughts of his heart to all generations.
>
> Psalm 33:11

These forms are **NOT** required for any children who will only be attending Family Day.

SUMMER CAMP PERMISSION SLIP / MEDICAL RELEASE FORM

Information for ALL campers needs to be included on this form.
Please mail form to: Starr Ferrari, 101 Oakmont Road, Mount Laurel, NJ 08054, (507) 261-7417.
This form must be received completed and signed prior to the beginning of Camp.

I hereby grant permission for my child/children listed below to participate in the Harbor Light Fellowship's Children's Fellowship Summer Camp from July 20 to July 22, 2023, including all activities and field trips. I have instructed my child/children to be cooperative at all times. I assume that all reasonable care will be taken by the advisors and workers to ensure the safety of all and therefore, I agree to hold them harmless in the event of accident or injury.

MEDICAL TREATMENT CONSENT FORM

To whom it may concern: I hereby grand permission for emergency medical treatment of:

(Name of Child)	*(Month / Day / Year of Birth)*	*(County and State of Birth)*
(Name of Child)	*(Month / Day / Year of Birth)*	*(County and State of Birth)*
(Name of Child)	*(Month / Day / Year of Birth)*	*(County and State of Birth)*
(Name of Child)	*(Month / Day / Year of Birth)*	*(County and State of Birth)*
(Name of Child)	*(Month / Day / Year of Birth)*	*(County and State of Birth)*
(Name of Child)	*(Month / Day / Year of Birth)*	*(County and State of Birth)*

(Home Address)

(Home Phone Number)	*(Cell Phone Number)*	*(Email Address)*

In the event of an accident or illness, I will be contacted as soon as possible thereafter. I can be reached at the following telephone numbers:

(Phone Number)	*(Phone Number)*	*(Phone Number)*

SUMMER CAMP PERMISSION SLIP / MEDICAL RELEASE FORM (page 2)

My child/children has/have allergies or any medical condition: ☐ Yes ☐ No

If you answered "Yes", are any of these life threatening? ☐ Yes ☐ No

Please specify child, allergy or medical condition, treatment, and whether the allergy or medical condition is life threatening on the "Health History and Authorization Form".

Other important information for emergency treatment:

_____

_____

_____

_____

_____

_____

(Family Physician) *(Phone Number)*

_____

(Insurance Carrier) *(Subscriber Name)* *(Policy Group ID)* *(Member ID)*

_____

(Parent / Guardian Signature)

_____

(Name of Parent / Guardian) *(Relationship to Child / Children)* *(Month / Day / Year)*

SUMMER CAMP PERMISSION SLIP / MEDICAL RELEASE FORM

This form is required for Information for each child aged 3 and over.
Please mail form to: Starr Ferrari, 101 Oakmont Road, Mount Laurel, NJ 08054, (507) 261-7417.
This form must be received completed and signed prior to the beginning of Camp.

(Name of Child) *(Month / Day / Year of Birth)* *(Age)*

(Name of Parent / Guardian) *(Phone Number)*

(Name of Parent / Guardian) *(Phone Number)*

Medical History: Please include all conditions that apply to your child

Condition (Check Yes or No)		**If Yes, please explain how condition is treated and what medication is used (if applicable), including rescue medication (i.e. Epi-pens, inhalers, etc.) Also indicate if the allergy or condition is life threatening.**
Allergies	☐ Yes. ☐ No	
Asthma	☐ Yes. ☐ No	
Diabetes	☐ Yes. ☐ No	
Seizures	☐ Yes. ☐ No	
Food Restrictions	☐ Yes. ☐ No	
Other Medical Conditions	☐ Yes. ☐ No	

Permission to administer medications

If my child has a headache, I authorize the Third Aid staff to administer (check all that apply):

- ☐ Children's acetaminophen
- ☐ Children's Ibuprofen
- ☐ Call me before administering
- ☐ Do not administer anything

If my child has a stomachache, I authorize the Third Aid staff to administer (check all that apply):

- ☐ Children's antacid
- ☐ Children's Pepto Bismol
- ☐ Call me before administering
- ☐ Do not administer anything

If your child should require any other medication through third aid, you will be contacted prior to administration.

In the event of an accident or illness, you will be contacted as soon as possible thereafter.
If your child should need emergency treatment, he/she will be taken to the closest emergency room.

The information you provide on this form will only be shared with camp staff who require access to it to meet your child's health and safety needs while attending camp.

_____

(Parent / Guardian Signature) *(Month / Day / Year)*

MEDICATION ADMINISTRATION (STAFF ADMINISTRATION)

This form should be completed for any camper that will need to take a medication during camp hours OR requires a rescue medication to be on site to be used in an emergency situation.
Please mail form to: Starr Ferrari, 101 Oakmont Road, Mount Laurel, NJ 08054, (507) 261-7417.
This form must be received completed and signed prior to the beginning of Camp.

If your child requires a daily medication, and is staying at camp overnight, the medication will be kept and administered by trained third aid staff. For the health and safety of all children at camp, minors may not keep their medications with them in their overnight bags and may not self- administer while on site.

All medication must be brought to camp in its original container and must be labeled with the child's information by a pharmacist. It is preferred that if your child requires a daily medication, you bring the doses required (in an original container with pharmacy label) and keep the rest at home.

Child's Information

_____

(Name of Child) *(Month / Day / Year of Birth)* *(Age)*

_____

(Medical Condition)

_____

(Known Allergies)

_____

(Name of Parent / Guardian) *(Phone Number)*

_____

(Name of Parent / Guardian) *(Phone Number)*

Medication Information

_____

(Medication) *(Dose)*

Is this a daily medication? ☐ Yes ☐ No. If Yes, what time should it be given? _____.

Is this an emergency medication? ☐ Yes ☐ No

MEDICATION ADMINISTRATION (STAFF ADMINISTRATION) (page 2)

_____

(Medication) *(Dose)*

Is this a daily medication? ☐ Yes ☐ No. If Yes, what time should it be given? _____.

Is this an emergency medication? ☐ Yes ☐ No

Parent/Guardian Authorization for Staff Administration of a Daily Medication:
I request that the above medication be given to my child during camp hours by third aid staff.

_____

(Parent / Guardian Signature) *(Month / Day / Year)*

Parent/Guardian Authorization for Staff Administration of an Emergency Medication:
I request that the above medication be given to my child as prescribed in an emergency situation. Please note: 911 will be called if an anaphylactic reaction occurs and requires treatment.

_____

(Parent / Guardian Signature) *(Month / Day / Year)*