SCHOOL OF ARTS,
CULTURE AND SOCIETY

Summer Camp Medical Form

Student's Name:____**Date of Birth:**______________________

Name of Parent or Guardian:____

Address:____

Place of Employment:____

Home Phone:________________________________**Work Phone:**____

If away from home/work during camp, please indicate how to reach you in an emergency:

____

Alternate Contact

Name:____**Phone:**____________________________________

Name of Insurance Co.:____**Policy #:**______________________________

In whose name is the insurance listed?:____

Does the participant have any special dietary needs? Yes No **If so, please describe:**

____

____

Does the student have a disability that requires special accommodations? Yes No

If so, please describe:

____

____

__Parent/guardian__, please read, date and sign the following:

If my child needs medical treatment while participating in the camp, it is my wish that treatment be started immediately if it is deemed necessary by a physician, with the understanding that every effort will be made to notify me in case of any major injury or illness. I will accept responsibility for all costs relatedto such treatment.

Parent/Guardian Signature:

____Date:____________________

Medications

Please list any medications your child is currently taking:

Prescription:____

Over the Counter:____

Drug Sensitivities:____

Allergies:____

Please circle any of the following that you approve workshop staff, including the designated Resident Assistant administer to your child? (circle)

Tylenol Benadryl Tums

__Students__, please read, date and sign the following:

I, _________________________, am aware that I may NOT share any medications with other participants.

Student Signature:____Date:___________

__Parent/Guardian__, please read, date and sign the following:

______________________ will bring the following medications with them to the workshop. They have my
(name of student)
permission to take the medications, only as dispensed by their designated Resident Assistant, and only according to the prescribed directions on the container. *The student may not share them with any other participant.*

Medications:____

____

Parent/Guardian Signature:______________________________________Date:___________

Mail to address:

Messiah University
Psychology Summer Camp
Department of Psychology, Criminal Justice and Sociology
One University Avenue
Mechanicsburg, PA 17055

or

Scan and email:

PsychologyCamp@messiah.edu