

Camper Name:

Child's Medicaid #

Case Number

HEALTH HISTORY

Indicate all known allergies, illness, disabilities, physical limitations, or medical complications:

Allergies

Illnesses/medical complications

Disabilities/Limitations

Leg or Arm Braces

Hearing Aids

Eating Disorder

Yes

No

Indicate any that apply:

Respiratory Problems

Hypoglycemia

Musculoskeletal Allergies

Heart or Circulation

Dizzy Spells

Pulmonary Edema

Seizure Disorders

Hay Fever

Anaphylactic Shock

Poison Oak

Balance Problems

Diabetes

Fainting

Drug Allergy

Other

Details from above:

Any specific activities to be restricted?

PRESCRIPTION MEDICATIONS: All medication sent to camp must be in original container with the pharmacy label on it.

Is your child taking any medications?

No

Yes, please fill in the following.

1. Name

Dosage

Times

2. Name

Dosage

Times

3. Name

Dosage

Times

4. Name

Dosage

Times

What is(are) the medication(s) for:

Doctor's Name

Phone

Please add any other comments related to HEALTH and MEDICATIONS below.

PERMISSION TO ADMINISTER OVER-THE-COUNTER MEDICATIONS

I hereby give the Camp Rock Forward Registered Nurse permission to administer the following products according to manufacturer's instructions, or as otherwise specified. I trust the Camp Rock Forward Registered Nurse to use their best judgment as situations arise, and if in doubt, he/she can call for verification.

Please check YES or NO for the medications listed below. This form must be filled out by the primary caregiver who signs below, or camper may not attend camp.

Yes	No	Yes	No	Yes	No
	Sunblock		Rash ointment		Tylenol
	Antiseptic ointment		Band-aids		Anti-itch cream
	Hydrogen peroxide		Cough syrup		Cough drops
	Decongestant		Antihistamine		Ipecac syrup

Specify Other

MEDICAL RELEASE FORM:

I understand that it is my responsibility as caregiver to make sure that all instructions are clear, and that the necessary dosage is adequately supplied for the duration of camp. I hereby authorize the Camp Rock Forward nurse to administer the above medication from **June 15- 19, 2026**.

This health history is correct so far as I know, and the above-named minor has permission to engage in all prescribed program activities, except as noted.

I the undersigned do hereby authorize the directors of Camp Rock Forward or such substitute as they may designate as agent for the undersigned to consent to an X-Ray examination, anesthetic, medical, dental or surgical diagnosis or treatment and hospital care for the above minor which is deemed advisable by and to be rendered under the general or special supervision of any physician and surgeon, licensed under the provision of the Medicine Practice Act or any dentist licensed under the Dental Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or dentist, at a hospital, camp or elsewhere. This authorization will remain effective while the above minor is enroute to and from or involved in or participating in any camp program, unless revoked in writing by the undersigned and delivered to the Director of Camp Rock Forward as legal guardian/social worker/other.

I give my permission for _____ to attend Camp Rock Forward, travel out of state, and for Camp Rock Forward to administer prescription and over the counter medications as noted above.

DCFS Guardianship Authorized Signature

Date