Additional Medical Needs Form

Child's Name: _____ Date of birth ___/___/_____

Dates attending: _____

Church Group Name: _____

The following portion to be completed by camper's Physician / Clinician:

Specialized Health Care Treatment / Procedure that may be required while at Camp
(Specify dosage, time, route, duration for ANY medication)

Illness/Condition: _____

Clinicial Orders:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Clinician's Signature: _____ Date: _____/_____/_____

Clinician's Phone: _____ Fax: _____

MD Stamp:

The following portion to be completed by camper's parent.

☐ I hereby authorize the first aid staff at Forest Home Christian Camp to administer the above treatments as authorized by my child's physician.

Parents Signature: _____ Date:_____/_____/_____

Parents Phone: _____

Place a copy of the completed form in a zip baggie with the medication.
If no medication is being sent, please fax/email
Fax # (909) 389-2221 / Email: firstaid@foresthome.org