RIDER UNIVERSITY
College of Continuing Studies

College of Continuing Studies
High School/Middle School
Summer Programs

Medical Form

ALL INFORMATION SUPPLIED IS STRICTLY CONFIDENTIAL. PLEASE TYPE OR PRINT *LEGIBLY*.
A copy of this form will be sent to the hospital in the event of an emergency.

Student _____ Date of Birth ____/____/____
(Last Name) *(First Name)* *(Middle Initial)*

Home Address: _____
(Street Address) *(City, State, Zip)*

Camp(s) Attending _____

CONTACT INFORMATION: Home Phone (___) - ____ - _____

	NAME	WORK PHONE	CELL PHONE
MOTHER		(___) - ____ - _____	(___) - ____ - _____
FATHER		(___) - ____ - _____	(___) - ____ - _____

MEDICAL RELEASE: In the event of an emergency, Rider University has my permission to contact the Princeton/Lawrenceville First Aid and Rescue Squad, who will proceed as necessary. In case of serious injury or illness, my child can be transported to the Emergency Room at University Medical Center at Princeton, Capital Health Mercer Medical Center in Trenton, Helene Fuld Medical Center in Trenton or St. Francis Medical Center in Trenton, where they may proceed with treatment including but not limited to medications, injections, anesthesia, and surgery.

Please print name of parent or guardian: _____

Signature of parent or guardian _____ Date _____

Family Physician _____ Office Phone: (___) - ____ - _____

Insurance Carrier _____ Policy Number _____

Name of Insured _____

HEALTH HISTORY:
Date of last tetanus shot _____/____/_____ Circle if Current (within ten years.) Yes No

Physical Limitations: Does your child have any physical limitations which might present a special problem, such as any health factor which may require them to follow a limited program of activities?
NO___ YES *(please list)* _____

Please list any conditions such as recent surgery, reoccurring or infrequent occurrences of mild allergies, hay fever, emotional problems, ADHD, etc.

_____

_____

Does your child have any serious illness? (i.e. heart disease, diabetes, depression)?
NO___ YES *(please list)* _____

Medical Form for: _____

Camp/s: _____

Does your child have any serious or life threatening allergies, including food allergies, (i.e. bee stings, peanuts, dairy, allergies to medications)?
NO___ YES *(please list)* _____

Please list all prescription medications your child will be taking while at camp. **NOTE**: All prescription medications must be in prescription bottles from the pharmacy, appropriately labeled with the Physician's name, the drug name, dosage, and times to be taken. **NO EXCEPTIONS**.

PRESCRIPTION MEDICATION	DOSAGE

Please list all **over the counter** medications your child will be taking while at camp. **NOTE**:
All OTC medications must be in their original packaging, with your child's name on the bottle.
Please do not send medications in alternate packaging.
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OTC MEDICATION	DOSAGE

All medications, with the exception of asthma inhalers, will be turned in to our counselors upon check in. They will keep and distribute all medications to your child as needed.

We keep a supply of the items listed below on hand. Please circle any items below that we have permission to administer to your child as needed.

ADVIL	YES NO	ASPIRIN	YES NO
Bee Sting Swabs	YES NO	BENADRYL	YES NO
Calamine Lotion	YES NO	MOTRIN	YES NO
Triple Antibiotic Ointment	YES NO	TYLENOL	YES NO

This health history is correct to the best of my knowledge, and the student named above has permission to engage in all activities unless otherwise noted. My child and I have reviewed all regulations pertaining to Westminster's Summer Programs, and we understand that failure to abide by these regulations will result in immediate dismissal from the program, at the expense of the parent or guardian, without refund.

Participants name *(please print):* _____

Participants signature: _____

Parents name *(please print):* _____

Parents signature: _____