UA LITTLE ROCK | HEALTH SERVICES

MEDICAL HISTORY & CONSENT FOR TREATMENT
REQUIRED FOR CAMPS AT THE UNIVERSITY OF ARKANSAS AT LITTLE ROCK

Name of Camp _____ Start Date _____ End Date _____

Camper's Name _____ Age_____ Date of Birth: _____

Camper's Address _____
City State Zip

Parent/Guardian Name _____

Home Phone _____ Cell Phone _____ Work Phone _____

EMERGENCY CONTACT – Please provide the names of two people to notify or to whom we can release the camper if a parent or guardian cannot be reached in case of an emergency.

NAME _____ RELATIONSHIP _____ Phone #: _____

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Check all conditions the camper currently has or has had in the past.

❑ Abdominal Problems	❑ Cancer	❑ Eating Disorder	❑ Kidney Problems	❑ Sickle Cell
❑ Asthma	❑ Constipation	❑ Frequent Colds	❑ Menstrual Problems	❑ Sinusitis
❑ Bed Wetting	❑ Diabetes	❑ Heart Problems	❑ Nausea	❑ Sleepwalking
❑ Bronchitis	❑ Ear/Throat Problems	❑ Homesickness	❑ Seizures	❑ Vomiting

IMMUNIZATIONS: Last Tetanus shot (Date) _____

KNOWN ALLERGIES: ❑ Food: _____ ❑ Drug(s): _____ ❑ Latex ❑ Insect Bites ❑ Bee Stings

Do you use an epi-pen? ❑ Yes ❑ No Do you have asthma or use an inhaler? ❑ Yes ❑ No

Are there other medical conditions we need to be aware of? _____

Describe any physical conditions that will restrict participation in this camp program. _____

MEDICATION CONSENT

If the medication consent section is not fully completed, medications will not be administered to the camper.

CURRENT OVER-THE-COUNTER (OTC) MEDICATIONS USED AS NEEDED

1. _____ 2. _____ 3. _____ 4. _____

I authorize my child to take their own OTC medications. ❑ Yes ❑ No
OR
I authorize the camp representative to administer the above OTC medications, as deemed necessary.
❑ Yes ❑ No

I authorize the licensed healthcare staff in Health Services to administer OTC medications Acetaminophen (Tylenol), Advil (Ibuprofen) and/or Benadryl as deemed necessary (no other OTC medications will be administered in Health Services). ❑ Yes ❑ No

CURRENT PRESCRIPTION MEDICATIONS (Include dosage schedule):

1. _____ 2. _____ 3. _____ 4. _____

Arkansas State Law requires parental authorization to administer any prescription medications brought by campers. Prescribed medication MUST be in its original container with the pharmacy label showing the prescription number, patient name, date filled, physician name, name of medication, and directions for use.

I authorize my child to take their own prescription medication. ❑ Yes ❑ No
OR
I authorize the camp representative to administer to my child his/her prescribed medication(s) being brought to camp.
❑ Yes ❑ No

Please note: Health Services staff will NOT administer prescription medications to the summer camp participants.

PARENT/GUARDIAN CONSENT FOR TREATMENT

I understand that I am giving consent for my child to visit the on-campus Health Services clinic and receive first aid treatment, if needed, from a licensed healthcare provider. I understand that I am also giving consent for the licensed healthcare providers in Health Services to administer acetaminophen, ibuprofen, or Benadryl, as deemed necessary. Health Services will not provide episodic illness care. I understand that if my child becomes ill while at camp, they will be referred to a local urgent care clinic.

I also understand that in case of an emergency, every effort will be made to contact me prior to treatment or transport. However, if I cannot be reached and the situation requires immediate emergency attention as determined by camp staff or the Health Services medical staff, I hereby authorize said personnel to obtain emergency treatment for my child as deemed necessary. I agree to the release of any records necessary for the treatment or referral of my minor child.

Parent/Guardian signature _____ *Date* _____

Parent/Guardian printed name _____

HIPAA REGULATIONS / PRIVACY POLICY

UA Little Rock Health Services complies with all state and federal HIPAA regulations. If the camper is 18 years of age or older, all information pertaining to clinic visits is confidential. The camper must give written consent if they want their health/medical information shared with anyone else. Please list below who we may discuss your health/medical information with, i.e. parent, guardian, camp representative.

1. _____ 2. _____ 3. _____

Camper/Patient Signature: _____ Date: _____

PARENTS/GUARDIANS – If your child is under the age of 18, please list those individuals with whom Health Services can share medical information, i.e. camp representatives.

1. _____ 2. _____ 3. _____

Parent/Guardian Signature _____ Date _____