

# Pepperhill Farm

## Pre-School and Summer Day Camp

### *Confidential Questionnaire*



*(To be completed by parent)*

Child's Name \_\_\_\_\_

Boy

Girl

<b>Drug Allergies</b>	Name Of Medication: _____	<input type="checkbox"/> None Known
<b>Food Allergies</b>	Name of Food: _____	<input type="checkbox"/> None Known
<b>Is your child allergic to Bee/Insect Stings?</b>	_____	<input type="checkbox"/> Non Known
<b>What type reaction did he/she have?</b>	<input type="checkbox"/> Severe Swelling, difficulty breathing  <input type="checkbox"/> Moderate Swelling  <input type="checkbox"/> Mild Swelling	"Epi -Pen " will be supplied by parent.  Ice applied and Benadryl Elixir administered.  Ice Applied to reduce swelling at site.

The school/camp personnel have my permission to administer the following over the counter medication(s) according to label directions at his/her discretion. Please check either "yes" or "no" for each item. If your child is allergic to any of these medications, the school requires an alternative remedy (labeled with your child's name) to the school for the child's use.

<b>7 UP</b>	<b>Upset Stomach</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Acetaminophen (non aspirin)</b>	<b>Fever and Headache</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Benadryl Elixir</b>	<b>Allergic reaction to bite/sting</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Benadryl Topical Spray</b>	<b>Itching</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Diaper Ointment</b>	<b>Diaper Rash</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No

Any other information relating to the medical care of your child that our school/camp personnel needs to know, such as daily medications, difficulty in swallowing pills, motion sickness, use of earplugs or glasses. \_\_\_\_\_

→ Sign: \_\_\_\_\_ (Mother)

Date: \_\_\_\_\_

→ Sign: \_\_\_\_\_ (Father)

Date: \_\_\_\_\_