**Camper Health Form**

Michigan Area United Methodist

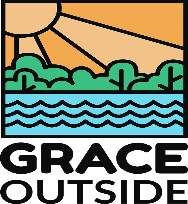
Camping

P.O. Box 134

St Johns, Mi 48879

989-534-6587

All campers age 18 and under are required by law to have a health form completed by their parent/guardian on file at the camp site for use by the Health Official during that camp. Campers over 18 must submit a completed form for themselves



For Office Use:

Account #

Date completed

Camper’s name-Last First Nickname

Street Address City State Zip

Camper’s date of birth mm/dd/yyyy Grade next school year

Custodial Parent/Guardian Name

Phone # (Cell preferred) Mother Dad

Additional Emergency Contact Name/Relationship Emergency Contact Number (cell preferred)

**CAMPER SIGNATURE**: I agree to abide by the rules of camp and will endeavor to be a responsible and willing participant in the activities of the camp throughout the entire week. Failure to do so could mean expulsion from camp and forfeiting all fees. I also agree to abide by any restrictions placed on my participation in camp activities by my physician, and parent/guardian or as written herein.

**Camper’s Signature Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PARENT/GUARDIAN AUTHORIZATION** Please read and sign, indicating your authorization:

Routine Care: I grant permission for the Health Officer to give my child first aid and treat illnesses in accordance with the camp’s Standard Care Procedures approved yearly by a physician.

Emergency Care: I grant permission to the camp Health Officer to secure emergency medical/surgical treatment, if necessary, for the camper named on this form while at camp. I understand the camp will make every possible effort to contact me prior to emergency treatment. In the event I am unavailable, emergency treatment will not be withheld or delayed to contact me. I give permission for my child to be transported for treatment, if the Health Officer deems it safe, in a private camp vehicle if I am unable to transport them, or by ambulance if indicated for the camper’s safety. Costs associated with illness/injury-the camp will not be responsible for any costs incurred as a result of treatment or transportation due to illness or injury.

Assumption of Risks: Having read the camp description, I understand there are risks inherent to camping activities (outdoor activities, sports, aquatics, etc.) and I grant permission for my child to participate.

**Parent/Guardian Signature: Date**

**INSURANCE:** Is the camper covered by family medical/hospital insurance? 🞏 yes 🞏 no

Please bring a front-and-back photocopy of your insurance card to check-in at camp, OR complete the fields below

Name of primary insurance provider Name of Health Insurance Company

Contact Number: Plan Code: Group Number:

**Allergies**  🞏 I have no known allergies

**Food allergies.** Describe food, reaction and management

**Environmental allergies** Describe reaction and management

**Medication allergies**. Describe reaction and management

**NUTRITION:** The camp kitchen can work to accommodate food allergies and most medically prescribed diets, but can not cater to individual food preferences Describe any dietary needs or restrictions. (Vegan, Vegetarian, Gluten, lactose intolerant) Contact the

camp 2 weeks prior to camp to make arrangements.

**Medications Medications must be given to the camp Health Officer at check-in for dispensing at the designated times. All medications (over the counter and prescription) by law must be locked securely in the Camp Health Center. Talk with the Health Officer for exceptions (inhalers, epi pens) ALL MEDICATIONS MUST BE SENT IN THEIR ORIGINAL CONTAINERS, LABELED FOR THAT CAMPER WITH MEDICATION NAME, DOSAGE/FREQUENCY TO BE GIVEN AND THE NAME OF THE PRESCRIBING PHYSICIAN ON THE LABEL** Medications are dispensed at meals and bedtime unless it is critical, they be given at a different time (anti-seizure, psych meds)

Please list medications to be given at camp, both prescription and non-prescription. State the drug name, dosage, frequency, time of day to be given

Medication #1:

Medication #2:

Medication #3:

Medication #4:

Medication #5:

Inhalers used as needed 🞏Camper kept (report to the health officer when used) 🞏 Given to Health Officer

**The camp stocks the following medication. Please do not send additional amounts unless given routinely.**

Acetaminophen (Tylenol) Ibuprofen (Motrin) Diphenhydramine (Benadryl) Decongestant, Allergy medicine-loratadine (Claritin), Antacid, Cepecol throat lozenges, Calamine lotion, Cough drops, Cough suppressant, Imodium (Anti-diarrhea) Hydrocortisone Cream

**Please Check one** 🞏 It is ok to give my child these if indicated per camp Standard Orders

🞏 It is ok to use these meds except \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH CONDITIONS**:

Please check all that are applicable. 🞏 Has had a recent injury, illness, operation

🞏 Has a chronic illness/condition (ear aches, sore throats) 🞏 Has diabetes

🞏 Has had a seizure 🞏 Has a heart defect/heart disease

🞏 Has asthma, wheezing, hay fever 🞏 Has a history of sleep walking

🞏 Has a history of bed wetting 🞏 Allergy to bee stings

🞏 Girl has been told about menstruation 🞏 Immunizations up to date

🞏 Has had a concussion **Date of last tetanus shot**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe any activity restrictions and/or other past, or ongoing medical care or conditions not listed

**\*\*Please share any information that might be helpful** to the staff in providing the most positive camp experience possible, such as recent changes in family, learning/behavioral challenges, other issues that are positively or negatively affecting him/her at this time. The information will only be shared with those directly caring for your camper and be kept confidential.

**E-signature**

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_