Camp Au Sable

2590 Camp Au Sable Drive Grayling, MI 49738 989.348.5491

Camper Medical Information

PLEASE DO **NOT** MAIL OR FAX BACK

To ensure confidentiality and up-to-date information, please fill out just prior to start of camp and give to camp nurse at registration.

Camper's Name: _____ **Cabin/Counselor:** _____/_____
Last *First* *(office use only)*

Date of Birth: _____ **Age:** _____ **Male:** _____ **Female:** _____
Mo/Day/Yr

Please check week(s) attending: Adventure/Jr Junior ____ Junior ____ Tween ____ Teen Canoe/Backpack ____
Teen ____ Specialty ____ Father/Son Canoe/Backpack____ Family I ____ Family II ____ Family III ____

Parent/Legal Guardian: _____ **Emergency Contact:** _____

Address: _____
Street or PO Box *City* *State* *Zip Code*

Emergency Phone Numbers: Day: ( ) _____ Evening: ( ) _____
Cell: ( ) _____

Insurance Information Attached: Yes ____ No ____ If no, please explain: _____
*Important Note: Must have a photocopy of health insurance card (**front and back**) in order to treat camper in an emergency!*

Physician/Health Care Facility: _____

Phone Number: ( ) _____ **Date of last physical exam:** _____

Are all school physicals/immunizations up to date: Yes _____ No _____ If not, please explain: _____

Date of last tetanus (DPT/TD) _____ **If needed, may tetanus booster be given?** Yes _____ No _____
Mo/Yr

Allergies:	**No Allergies**	**Medication Allergies**	**Food Allergies**	**Other Allergies**
	_____	_____	_____	_____
		_____	_____	_____
		_____	_____	_____

Routine Medication:

_____
_____
_____
_____

Prefer private medication administration ☐

Camper's Health History – Please Check

	Yes	No		Yes	No
1. Upset stomach?	_____	_____	7. Recent injury, infection, infectious disease?	_____	_____
2. Frequent ear infections?	_____	_____	8. Chronic or recurring illness/conditions?	_____	_____
3. Frequent headaches?	_____	_____	9. Any physical restrictions?	_____	_____
4. Ever had seizures?	_____	_____	10. If female, menstrual difficulties?	_____	_____
5. Diabetes?	_____	_____	11. Any other health conditions requiring treatment?	_____	_____
6. Asthma?	_____	_____	12. Any past medical treatment/operations?	_____	_____

If "yes" please explain:

_____
_____
_____
_____

◇ ***There will be a head lice check at registration. Each camper must be lice-free before they can be checked into a cabin.***
(To be initialed by medical staff at registration: no lice _____ recheck _____ yes _____)

I hereby give Camp Au Sable permission to provide routine health care (which includes over-the-counter drugs, first-aid for cuts, sprains, bruises, etc.), administer prescription medications, and seek emergency treatment as needed. In case of emergency, I hereby give permission to the camp physicians selected by the camp directors to secure proper treatment including: routine tests, x-rays, treatment, hospitalization, anesthesia, surgery, and to release any records necessary, as well as to provide or arrange necessary related transportation. I certify that the above information is correct and current to the best of my knowledge.

_____ _____ _____ _____
Signature of Parent/Guardian **Date** **Camp Nurse** **Date**

Name ____________________________________
Last *First*

Date	Time	Medical Notes