Camper Health Form

Michigan Area United Methodist Camping
PO Box 134, St Johns, Mi 48879
989-534-6587

For Office Use. Date:
Account #

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.

Please PRINT
Camper's Name-Last______________________ First ______________________ Nickname ______________________

Street Address ____________________________________ City ______________________ State ______ Zip ___________

Camper's date of birth mm/dd/yyyy ____ / ____/ __________ Grade upcoming school year _____________

Custodial Parent/Guardian Name ___________________________ Parent/Guardian 2 Name ____________________________

Phone # (cell preferred) Parent 1 _____________________________ Ph Parent 2 ___________________________________

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**

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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.

Primary insurance provider: ___________________________________ Health Insurance Company: _____________________

Ph Number: ____________________________ Plan Code: ______________________ Group Number: _________________

ALLERGIES I have no known allergies See below and next page for 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 cannot cater to individual food preferences. Describe any dietary needs or restrictions. (vegan, vegetarian, gluten-free, lactose intolerant) Please 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	Dose	Frequency	Time of Day *breakfast/lunch/dinner/bedtime*

Inhalers 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 a chronic illness/condition (ear aches, sore throats)
- Has had a seizure
- Has asthma, wheezing, hay fever
- Has a history of bed wetting
- Girl has been told about menstruation
- Has had a concussion
- Has had a recent injury, illness, operation
- Has diabetes
- Has a heart defect/heart disease
- Has a history of sleep walking
- Allergy to bee stings
- Immunizations up to date

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. Attach a separate page if necessary.

Signature____Date______________________