MI Area UM Camping **Health Record** The United Methodist Church

The following information will assist the camp health care provider in identifying the appropriate care and needs of your camper. A parent/guardian should fill out this form. No camper will be admitted without this form. Any changes to this form must be provided to the camp Health Officer upon arrival at camp. Please read carefully and complete all applicable fields.

Name_____ **Age** _____ **Birth Date** _____ **Gender** **Male** **Female**
Last *First* *Middle*

Home Address_____
Address *City* *State* *Zip code*

Home Phone _____ **Cell Phone** _____ **Email** _____

Custodial Parent/Guardian Name _____ **Cell Phone**_____

Second Custodial Parent/Guardian Name _____ **Cell Phone**_____

If above not available in an emergency, notify:

Emergency Contact _____ **Relationship** _____

Home Phone _____ **Cell Phone** _____

Signatures &Parent/Guardian Authorization (for staff under 18 years of age): This health form is correct as far as I know and the person herein described has permission to engage in all camp activities except as noted on the back of this form.

- **Health Care:** I give the camp health officer permission to give me/my child over-the-counter and prescription medications in accordance with the standing orders approved by the camp physician.
- **Permission to Treat:** I hereby give permission to the medical personnel selected by the Camp Director to provide routine health care, to administer medications and to order X-rays, routine tests and treatment for me/my child, and in the event I cannot be reached in an emergency, I hereby give permission to the medical personnel selected by the Camp Director to hospitalize, secure proper treatment, review my/my child's medical records, discuss my/my child's conditions with any medical personnel, and to order injection and anesthesia and/or surgery for me/my child as named above. This form may be photocopied for use out of the camp.
- **Transportation Authorization:** I give permission for me/my child to be transported in private vehicle if necessary.
- **Additional Release:** I release all photos, videos and audio tapes of me/ to MAUMC to be used for promotional purposes. Check here ◯ if you do NOT give media release permission.
  I acknowledge that post-camp meetings, reunions, and voluntary events are not conducted under the supervision or auspices/sponsorship of MAUMC, which is not responsible for anyone's well-being at such events.
- **Signature of Parent /Guardian:**_____ Date_____
- Printed name: _____
- **Camper Signature**: I agree to abide by any restrictions placed on my participation in camp activities by my physician, parents/guardian or as written herein. 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. _____
  _____Date _____

Allergies: *Check those that apply to you*.

_____ I have no known allergies.

_____ I have an allergy to this/these food/s: Describe reaction and management of reaction:

_____ _____

_____ _____

_____ _____

_____ _____

_____ I am allergic to this medication/s:_____

_____ I am allergic to these substances: _____

Describe what happens if you take/come in contact with this and how the reaction is managed:_____

_____

_____

_____

Name: _____ *Last* *First* *Middle* Session: 1 2 3 4 5 6 7 8 Cabin: _____ Year: _____

Medication: By law all medication must be locked securely in the camp Health Center, unless required to be in the immediate possession/control of the user (i.e. inhalers, epipen, etc.). All medication, prescription and otherwise, should be in the original container and submitted, including Psychiatric, Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD). Inhalers/epipens will be distributed after check-in. The dosage/frequency schedule identified by the physician will be administered by the camp health provider.

_____ I have no medications with me at camp.

Medication (Prescription and Non-Prescription)	Dosage	Frequency (Specific Time)	Reason for Taking	To be taken during camp?
1.				☐ Yes ☐ No
2.				☐ Yes ☐ No
3.				☐ Yes ☐ No
4.				☐ Yes ☐ No
5.				☐ Yes ☐ No
6.				☐ Yes ☐ No
7.				☐ Yes ☐ No

Primary Physician _____ **Phone** _____

Dentist _____ **Phone** _____

Insurance Information: Is the above named covered by family medial/hospital insurance? ☐ Yes ☐ No

Family Health Insurance Co. _____

Contract # _____ **Plan Code** _____ **Group #** _____

Please attach a photocopy of Insurance Card.

(A physical examination by a physician is **not required**. If the camper has had a physical within the past 12 months, you may attach a copy to this form.

Immunization Record

Are the camper's immunizations up-to-date? ☐ Yes ☐ No

Immunizations:	Polio	Mumps	Diphtheria	Tetanus	Pertussis	Measles	Rubella	Hep B	Others
Date first Completed									
Most Recent Booster									

Nutrition: *The camp kitchen can work effectively with some medically prescribed diets but does no cater to individual preferences.*

_____ I eat a regular, varied diet.

_____ I am lactose-intolerant. _____ I am gluten intolerant.

_____ I am a Vegetarian. _____ I am a Vegan

Describe any dietary needs or restrictions: _____

Medical History

	Circle Yes No		Circle Yes No
Has had a recent injury, operation, illness, or infections disease	Yes No	Has trouble passing urine or bowl movements	Yes No
Has a chronic illness/condition (colds, ear aches, sore throat)	Yes No	Wears glasses, contacts, or protective eye wear	Yes No
Has autism spectrum disorder **	Yes No	Has Shortness of breath	Yes No
Has ADD or ADHD **	Yes No	Has a history of sleep walking	Yes No
Has diabetes	Yes No	Has a history of bed wetting	Yes No
Has/had an eating disorder	Yes No	Has/had menstrual problems	Yes No
Has ever had a seizure	Yes No	Has a bleeding/clotting disorder	Yes No
Has a heart defect/disease	Yes No	Has dental problems	Yes No
Has hay Fever, asthma, wheezing	Yes No	If female, has been told about menstruation	Yes No
Has had mononucleosis in the past 12 mos.	Yes No	If female, has menstruated	Yes No
Has camper ever been stung by a bee	Yes No	If yes, Normal or Serious	Please explain serious below.

If ** is indicated, please contact the director/dean a minimum of 3 weeks prior to the session to assist us with our staff/volunteer and cabin assignments. Please assist us so we can provide the best camping experience for your child!

Please explain all questions to which you answered yes and/or describe any other past, current, or on-going medical treatment.

Please describe any camp activities from which camper/staff should be exempted for health reasons.

Confidential Camp Staff Guidance: Please describe if there is any other emotional/social/physical condition which camp should be informed. Such as a change in the family (new baby, death, re-marriage or divorce, re-location of the family, illness in the family, etc.) or anything that you feel is affecting your child either positively or negatively. Include how you feel your child is affected in his/her relationship with others. The more we know about campers, the more helpful we can be.

For Camp Personnel Only

1. Is the emergency authorization on page one of the health record signed? □ Yes □ No
2. Have you been exposed o any contagious disease in the last two weeks? □ Yes □ No
3. Did you bring any over the counter medications with you? □ Yes □ No

   Is there an additional medication form needed to list additional meds? □ Yes □ No

   (The Health Care Provider will need to record all medications brought to camp.)
4. Any additions, corrections or clarifications to information on health history? Yes □ No □
5. Medication given to healthcare staff? Yes □ No □
6. Health Record completed online? Yes □ No □

Explanations: _____

_____

_____

Staff Member's Initial _____

Information received from: Mother Father Grandparent Camper

Guardian Other _____

Date, if different than registration date: _____