

## **HEALTH FORM DUE WEEK BEFORE START OF CAMP**

**This form needs to be filled out every year, except for the latter portion that needs to be completed by a licensed medical person at least every two years. If you are planning on using the physician portion of your health form from the previous year, you must confirm with the Mikell staff that the physician's portion of your camper's health form is still on file. Again, you must fill out a health form EVERY YEAR!!!**

**PLEASE DO THIS BEFORE THE DAY OF REGISTRATION!!!**

Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Gender: \_\_\_ Female \_\_\_ Male

Custodial Parent/Guardian \_\_\_\_\_ Home Phone \_\_\_\_\_

Business Phone \_\_\_\_\_ Mobile/Cell Phone \_\_\_\_\_

Address \_\_\_\_\_

Additional emergency contact \_\_\_\_\_ Phone \_\_\_\_\_

### **Insurance Information**

Is the participant covered by family medical/hospital insurance? \_\_\_ Yes \_\_\_ No

### **PLEASE ATTACH A COPY OF BOTH SIDES OF YOUR HEALTH INSURANCE CARD.**

Parent/Guardian Authorization: The camper listed on this form has permission to engage in all camp activities except as noted. I hereby give permission for necessary health care for my child as needed. I understand that I will be notified if my child has an illness or injury requiring a visit to a physician, or if he/she is incapacitated for more than 24 hours. I have supplied complete and accurate health information related to the camper or staff participation in specific activities.

I hereby give permission to any certified/licensed emergency health personnel and/or physicians to treat my child, including hospitalization, for the person named above.

Signature of parent/guardian \_\_\_\_\_

Printed Name \_\_\_\_\_ Date \_\_\_\_\_

List and explain any restrictions to activities: \_\_\_\_\_

\_\_\_\_\_

Camper's Last Name

Session

**Health History**

*The legal guardian or physician must fill out the following so we can be aware of any needs.*

**Allergies:**

Medical: \_\_\_\_\_

Food: \_\_\_\_\_

Other (Insect, asthma, latex, etc.):

\_\_\_\_\_

**Medications:**

\_\_\_\_ This person takes **NO** medications (including over the counter).

\_\_\_\_ This person takes the following medications:

Med #1: _____	Dosage _____	Frequency _____
Reason _____		
Med #2: _____	Dosage _____	Frequency _____
Reason _____		
Med #3: _____	Dosage _____	Frequency _____
Reason _____		
Med #4: _____	Dosage _____	Frequency _____
Reason _____		

Please indicate which of the following over the counter medications are allowed to be administered by our camp nurse:

	Y	N		Y	N		Y	N
<b>Acetaminophen</b>			<b>Sinus Meds</b>			<b>Antacids</b>		
<b>Ibuprofen</b>			<b>Pepto Bismol</b>			<b>Cough Medicine</b>		
<b>Benadryl</b>			<b>Kaopectate</b>			<b>Antibiotic Cream</b>		

Please list any contraindications or concerns about over the counter medications:

\_\_\_\_\_

**Dietary:**

Please list any dietary restrictions/needs: \_\_\_\_\_

\_\_\_\_\_

Has the camper:

- Yes  No      Had a recent injury, illness or infectious disease?
- Yes  No      Ever had a chronic or recurring illness/condition?
- Yes  No      Been hospitalized?
- Yes  No      Ever had surgery?
- Yes  No      Has behavioral issues?

If you answered “yes” to any of the above, please explain:

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**Immunization Record:**

Vaccine	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP	_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)	_____	_____	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____	_____
MMR	_____	_____				
Or Measles	_____	_____				
Or Mumps	_____	_____				
Or Rubella	_____	_____				
Haemophilus influenza B	_____	_____	_____	_____		
Hepatitis B	_____	_____	_____			
Varicella (chicken pox)	_____	_____				

Has the camper had:

- Measles    Chicken Pox    German measles    Mumps    Hepatitis A
- Hepatitis B    Hepatitis C

**Use this space to explain any additional information regarding the physical, emotional, or mental health of the camper about which the camp should be aware.**

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Name of pediatrician/family physician \_\_\_\_\_ Phone \_\_\_\_\_

Address: \_\_\_\_\_

Name of family dentist/orthodontist \_\_\_\_\_ Phone \_\_\_\_\_

Address: \_\_\_\_\_

For Mikell use only

**Rx received:**

**Additional notes:**

**\*Continue on next page for  
REQUIRED physician  
portion\***

# Licensed Medical Professional Form

## Required Every Two Years

I examined \_\_\_\_\_ on (date) \_\_\_\_\_.  
 (American Camping Association accreditation requirements specify exams within 24 months of camp attendance.)

BP \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

In my opinion, the above applicant \_\_\_ is \_\_\_ is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions:

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### **Recommendations and Restrictions for Camp**

Treatment to be continued at camp

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Medications to be administered at camp (name, dosage, frequency)

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Any medically-prescribed meal plan or dietary restrictions

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Known Allergies

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Description of any limitation or restriction on camp activities

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Additional information for health care staff at the camp

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**Signature of Licensed Medical Personnel** \_\_\_\_\_

Printed \_\_\_\_\_ Title \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Date \_\_\_\_\_