



HEALTH FORM 2011

- CAMPER
- TEAM ELIJAH
- STAFF MEMBER
- STAFF KID

Circle Week(s) of Attendance

HORSE CAMP 1/BUILT BOYS
 FAMILY CAMP 1 TTC
 GIRLS 1 2 3
 FAMILY CAMP 2 SCIENCE CAMP
 CAMP 101 HORSE CAMP 2
 S.O.A.R. 1 2 3

- **THIS FORM IS A REQUIREMENT OF ATTENDANCE. PLEASE PRINT.**
- BOTH SIDES MUST BE COMPLETED by parent/guardian of campers. No health exam is required. Annual update required.
- **Use a separate sheet of paper to give additional remarks or health issues.**
- Staff and staff children must also have a completed Health Form on file.

INDIVIDUAL INFORMATION

Name _____ Sex M F Birthdate _____ Age _____
 Home Address _____ Home Phone (____) _____
 City _____ State _____ Zip _____ Cell Phone (____) _____
 Custodial Parent/Guardian _____ Work Phone (____) _____
 Second Parent/Guardian _____ Contact Phone (____) _____

EMERGENCY CONTACTS

Parent/Guardian: I plan to be at home *or* I plan on traveling

(I will attach my itinerary & phone numbers)

When parent/guardian is not available, the following should be contacted:

Name _____ Contact Phone (____) _____
 Relationship _____ Alt Phone (____) _____

HEALTH ALERT

ALLERGIES

List and describe all known allergic reactions, warning signs and how we should manage.

1. allergy _____
reaction/manage _____
2. allergy _____
reaction/manage _____
3. allergy _____
reaction/manage _____
4. allergy _____
reaction/manage _____

CRITICAL HEALTH ISSUES - current & historical

Check and describe all that apply

- Asthma _____
- Heart _____
- Diabetes _____
- Hypoglycemia _____
- Convulsions / seizures / epilepsy _____
- Infectious disease _____

RESTRICTIONS

 Check and describe all that apply

- Dietary _____
- Physical Activity _____
- Other _____

BEHAVIORAL CONSIDERATIONS

Please check and give complete information on any of the following and any other issues that are necessary for the complete care of your child. Use separate sheet if needed.

- ADD/ADHD
- Learning disability
- Bedwetting
- Eating disorder/
anorexia/bulimia
- Cutting /self mutilation
- Psychiatric issues/
mental health
- Night terrors
- Sleep walking
- Other _____

IMMUNIZATION HISTORY

Please record date (month & year)

Immunization	DTP	Hib	MMR	Polio	Hep A	Hep B	Hep C
Series complete or booster							

- **Had chicken pox?** No Yes Date _____
or had **Varicella Vaccine** No Yes Date _____
- For persons age 15 & older: Date of last tetanus booster _____
- **STAFF MEMBERS ONLY:** Date of last TB-free test? _____
(Must attach proof of test given within previous 36 months)

Immunization history not used as screening device for participation.

MEDICATIONS	Medication Name	Dosage	Time /Frequency Taken	Daily or As Needed
List all meds taken, include over-the-counter, prescription, and vitamins. All meds and vitamins must be in original containers. Provide enough for the duration of the campers stay.				

EMERGENCY MEDICAL REFERENCE CONTACTS Date of last physical exam: _____

Name of physician _____ Phone (____) _____

Name of dentist _____ Phone (____) _____

Name of specialist/orthodontist _____ Phone (____) _____

PERMISSION **IMPORTANT: This box MUST be signed for attendance!**

To my knowledge this health history is correct, and the person herein described has permission to engage in all camp activities, on and off site, except as noted. I give my permission for any agent of Huron Forest Camp CedarRidge to pass the information in this Health History on to any doctor or medical personnel in the event that my child needs medical assistance. According to the federally mandated HIPAA (Health Insurance Portability and Accountability Act) we are committed to maintaining the privacy of your child's health history. Health information will only be available to certain staff members and even then, they will only be given the information deemed necessary to your child's well-being. Health forms will not be accessible to campers or staff. In case of emergency, this health history form will be placed in a sealed envelope and transported with your child to the hospital or clinic, where local health care professionals will have access to the information on it.

Emergency Authorization: I hereby give permission to the medical personnel selected by the camp administration to order x-rays, routine tests and treatment for me or my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp administration to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for me or my child as named.

X _____ Date _____
Signature of parent/guardian or adult camper/staff

RELEASE We know that participation in the planned program at camp has some inherent risks and do hereby release Huron Forest Camp CedarRidge and all their employees and agents from any claims for injuries resulting to minor children and adults involved in camp programs, and the undersigned agrees to hold Huron Forest Camp CedarRidge and their employees and agent harmless from any loss resulting from any claim by any child or adult in camp programs.

X _____ Date _____
Signature of parent/guardian

INSURANCE You have my permission to use the following medical/hospitalization insurance policy:

Name of Policy Holder _____ Please list insurance numbers on your card:
(Feel free to attach a photocopy of the card instead)

Social Security # of Policy Holder _____

Medical Insurance Company _____ #s | _____

Is the plan a: *Circle* HMO PPO
 Must call for emergency room care
 Must call prior to local doctor's visit or walk-in clinic

Company Phone Number for approval (____) _____

X _____ Date _____
Signature of parent / guardian

MAIL TO: Mail this form at least **ONE WEEK BEFORE CAMP**

BEFORE June 10 Mail to: **AFTER June 10 Mail to:**
 Huron Forest Camp CedarRidge - 36208 Freedom Rd, Huron Forest Camp CedarRidge - 1154 W. River Rd,
 Farmington, MI 48335 Oscoda, MI 48750
 Questions: (248) 615-9844 Metro Office Questions: (989) 739-3571 Camp