

Camp Michawana Health Form

Name _____ Date of Birth _____ Gender _____
 Last First

Address _____ City _____ St _____

Zip _____ Emergency Number _____

Immunization Records: Please indicate dates. State law requires all immunizations be up to date.

Tetanus/Diphtheria _____ Polio _____ Measles _____ Mumps _____

Rubella _____ Chicken Pox _____ Other _____

Health History: Please check if any apply

Convulsions ____, Rheumatic Fever ____, Asthma ____, Diabetes ____, Epilepsy ____,
Other _____

Allergies to: Aspirin ____ Penicillin ____ Other Drugs List _____

Food List _____ Insect Bites _____

I give permission to give my child over the counter medications if needed. ____ Yes ____ No

Heath Concerns: please list

Special Health or Behavior Needs

Surgeries or Injuries

Has this child been exposed to, or do you currently have any contagious diseases?

Medications: All medications must be in original prescription container with name, medication, strength & dosing

Medication	Purpose	Dosage
_____	_____	_____
_____	_____	_____
_____	_____	_____

Personal Insurance Information:

Company name _____ Group _____
Policy # _____ Policy holder _____
Phone # _____

In the event of illness, you/your parents are completely responsible for any necessary treatment cost incurred. Camp holds the secondary coverage status.

If there any religious or personal objections that do not allow your child to receive a physical exam and/or immunization, you must give a written statement that your child is in good health.

No religious objections, Yes I have religious objections.

I understand that in the unlikely event of a serious illness or injury, every effort will be made to notify the parent or guardian at the earliest possible time without jeopardizing the care of your child. Parents or guardians will be notified if their child receives treatment for an injury

or illness that requires a physician. In sign this document, I hereby certify that the above information is correct and complete; for the release of medical records in case of injury or illness; and for the camp health officer to perform routine minor medical treatment. In the event I can not be reached, I hereby give permission to the physician selected by Camp Michawana to give emergency medical or surgical treatment and other non-surgical medical care.

Signature (Parent or Guardian) Date _____