

Name _____ Birth date _____ Age _____ Male / Female
last first middle month / day / year circle one

Home Address _____
Street Address City State Zip

Custodial Parent/guardian _____ Phone _____

Home Address _____
(If different from above) Street Address City State Zip

Second parent/guardian or emergency contact _____
 Address _____ Phone _____
Street address City State Zip

If parent is not available in an emergency, notify _____
 Relationship _____ Phone numbers () ()

Medical Insurance Information:

Is the participant covered by family medical/hospital insurance? Yes No
 Insurance Company _____ Policy # _____
 Name of Insured _____ Insurance Company Phone _____

Allergies: No known allergies. This camper is allergic to: Food Medicine The environment (insect stings, hay fever, etc.) Other
(Please describe what the camper is allergic to and the reaction seen.)

Restrictions: I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.
 I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations. *(Please describe below.)*

Medications: This camper will NOT take any daily medications while attending camp.
 This camper will take the following daily medication (s) while at camp:

“Medication” is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. **The Michigan Camp Licensing Rules require that original pharmacy containers with labels which show the camper’s name and how the medication should be dispensed are used. Provide enough of each medication to last the entire time the camper will be at camp.**

Name of medication	Date started	Reason for taking it	When it is given	Amount or dose given	How it is given
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time:		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time:		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time:		

List any medications taken during the school year that the camper does not take during the summer. _____

Camper’s Physician: _____ Phone: _____
 Camper’s Dentist: _____ Phone: _____

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me on this form. I give permission to the physician selected by Camp Burt Shurly to order x-rays, routine tests, & treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission for the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a “need to know” basis with camp staff. I give permission to photocopy and/or electronically store this form. In addition, the camp has permission to obtain a copy of my child’s health record from providers who treat my child and these providers may talk with the program’s staff about my child’s health status.

Signature of custodial Parent/Guardian: _____ Date: _____ Relationship to Camper: _____

General & Emotional Health History: (Check “Yes” or “No” for each statement. Explain “Yes” answers below.

- | | |
|--|--|
| <p>Has/does the camper:</p> <ol style="list-style-type: none"> 1. Had any recent illness or infectious disease? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Have a chronic or recurring illness?..... <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Have problems with falling asleep / sleepwalking? <input type="checkbox"/> Yes <input type="checkbox"/> No 4. Had mononucleosis (mono) in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No 5. If female, have an abnormal menstrual history? <input type="checkbox"/> Yes <input type="checkbox"/> No 6. Passed out / had chest pain during exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No 7. Have any dietary restrictions? <input type="checkbox"/> Yes <input type="checkbox"/> No 8. Wear glasses, contacts, or protective eye wear? <input type="checkbox"/> Yes <input type="checkbox"/> No 9. Ever had frequent ear infections? <input type="checkbox"/> Yes <input type="checkbox"/> No 10. Had fainting or dizziness? <input type="checkbox"/> Yes <input type="checkbox"/> No 11. Ever had problems with joints (e.g. knees, ankles)? <input type="checkbox"/> Yes <input type="checkbox"/> No 12. Have any skin problems (e.g. itching, rash, acne)? <input type="checkbox"/> Yes <input type="checkbox"/> No 13. Ever been diagnosed with a heart murmur? <input type="checkbox"/> Yes <input type="checkbox"/> No 14. Had problems with diarrhea/constipation? <input type="checkbox"/> Yes <input type="checkbox"/> No 15. Have asthma and/or shortness of breath? <input type="checkbox"/> Yes <input type="checkbox"/> No 16. Traveled out of the country in the past 9 months? <input type="checkbox"/> Yes <input type="checkbox"/> No 17. Significant event that is affecting the camper’s life? (abuse, death in family, adoption, foster care, new sibling, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No | <ol style="list-style-type: none"> 18. Had a recent injury? <input type="checkbox"/> Yes <input type="checkbox"/> No 19. Ever had dental problems? <input type="checkbox"/> Yes <input type="checkbox"/> No 20. Have diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No 21. Have a history of bedwetting? <input type="checkbox"/> Yes <input type="checkbox"/> No 22. Ever been hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No 23. Ever had surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No 24. Ever had a head injury? <input type="checkbox"/> Yes <input type="checkbox"/> No 25. Ever had seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No 26. Ever had high blood pressure? <input type="checkbox"/> Yes <input type="checkbox"/> No 27. Ever had back problems? <input type="checkbox"/> Yes <input type="checkbox"/> No 28. Have frequent headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No 29. Ever had an eating disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No 30. Ever been knocked unconscious? <input type="checkbox"/> Yes <input type="checkbox"/> No 31. Emotional difficulties for which professional help was sought? <input type="checkbox"/> Yes <input type="checkbox"/> No 32. Treated for ADD or ADHD? <input type="checkbox"/> Yes <input type="checkbox"/> No |
|--|--|

Please explain “Yes” answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel. List also any other current medical, physical, mental, or psychological conditions requiring medication, treatment or special restrictions.

Immunization History: Provide the month and year for each immunization. Starred (*) immunizations must be current. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diphtheria, tetanus, pertussis * (DTaP) or (TdaP)						
Tetanus booster * (dT) or (TdaP)						
Mumps, measles, rubella * (MMR)						
Polio * (IPV)						
Haemophilus influenza type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) / or Had chicken pox—date? ____						
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test Date: _____ Negative Positive

If your camper has not been fully immunized, or if you cannot fully complete the Immunization Chart above, please sign the following statement: I understand and accept the risks to my child from not being fully immunized.

Signature of Custodial Parent / Guardian: _____ Date: _____ Relationship to camper: _____

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. **Cross out the items that should NOT be given.**

- | | | |
|---|---|--|
| Acetaminophen (Tylenol) | Ibuprofen (Advil, Motrin) | Lice shampoo or cream (Nix or Elimate) |
| Phenylephrine decongestant (Sudafed PE) | Pseudoephedrine decongestant (Sudafed) | Antibiotic cream |
| Antihistamine/allergy medicine | Guaifenesin cough syrup (Robitussin) | Calamine lotion |
| Diphenhydramine antihistamine/allergy medicine (Benadryl) | Dextromethorphan cough syrup (Robitussin DM) | Generic cough drops |
| Laxatives for constipation (Ex-Lax) | Sore throat spray | Aloe |
| | Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol) | |

List here any other medications that the camper should not take?