

# Camper Health & Medical Form Revised 9.8.14

Both sides must be completed by parent or guardian for participation at camp.  
Bring this form to camp at the time of registration. Please PRINT CLEARLY using a pen.

Camp Brethren Heights, 9478 Brethren Heights Rd., Rodney, MI 49342.



## Camper Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_\_ Gender: M / F

Name Camper prefers: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age at camp: \_\_\_\_\_

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

Insurance Information: Is the camper covered by health insurance? Y / N

Insurance Company: \_\_\_\_\_

Policy/Group Number: \_\_\_\_\_

## Emergency Contacts

Parents'/Guardians' names: \_\_\_\_\_ Family email: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Dad's cell: \_\_\_\_\_ Mom's cell: \_\_\_\_\_

Who to call if parent/guardian is not available: \_\_\_\_\_ Relation to camper: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

## Health History

Date of most recent medical exam: \_\_\_\_\_

Camper's Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

*If you answer yes below, please explain on a separate sheet or in comment section below.*

### Has/does the camper:

- |   |       |  |       |
|---|-------|--|-------|
| 1. Had any recent injury, illness or disease?     | Y / N | 11. Have a bleeding or clotting disorder?            | Y / N |
| 2. Have a chronic or recurring illness/condition? | Y / N | 12. Ever been diagnosed with a heart defect/disease? | Y / N |
| 3. Ever been hospitalized?                        | Y / N | 13. Wear glasses, contacts or protective eyewear?    | Y / N |
| 4. Have frequent headaches?                       | Y / N | 14. Brought an orthodontic appliance to camp?        | Y / N |
| 5. Ever had a seizure?                            | Y / N | 15. Have problems with sleepwalking?                 | Y / N |
| 6. Have diabetes?                                 | Y / N | 16. Have a history of bedwetting?                    | Y / N |
| 7. Have asthma?                                   | Y / N | 17. Ever had an eating disorder?                     | Y / N |
| 8. Ever had high blood pressure?                  | Y / N | 18. Ever been treated for emotional difficulties?    | Y / N |
| 9. Had mononucleosis in the past 12 months?       | Y / N | 19. *For girl campers only, has she menstruated?     | Y / N |
| 10. Ever had frequent ear infections?             | Y / N | If no, has she been told about menstruation?         | Y / N |

## Allergies

Please list any allergies the campers may have (medications, insect stings, food or other): \_\_\_\_\_

## Restrictions

The following restrictions apply to this camper; (attach additional paper if needed):

Dietary: \_\_\_\_\_

Explain any restrictions to activity (what **cannot** be done; what **adaptations or limitations** are necessary):

\_\_\_\_\_  
\_\_\_\_\_

## Medications

☐ My child will **not** be bringing any medication (prescription or non-prescription) to camp.

☐ My child will be bringing the following medication (prescription or non-prescription) **in its original container labeled with the child's name**. Please list the medications below, use additional paper if needed.

Medication(s):	Dosage:	Time:	Reason for taking medication:
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

## Immunization Record

Please give the date of the most recent boosters if known:

Polio \_\_\_\_\_ Mumps \_\_\_\_\_ Diphtheria \_\_\_\_\_ Tetanus \_\_\_\_\_ HIB \_\_\_\_\_

Measles \_\_\_\_\_ Rubella \_\_\_\_\_ Chicken Pox \_\_\_\_\_ Whooping Cough \_\_\_\_\_

Hepatitis B \_\_\_\_\_ Other \_\_\_\_\_

Anything else you would like our staff to know? \_\_\_\_\_

\_\_\_\_\_

## PARENT/GUARDIAN AUTHORIZATIONS:

The personal and medical information is correct and complete as far as I know. The person described has my permission to engage in all camp activities at Camp Brethren Heights as noted.

I give permission to the camp to provide routine health care, administer prescribed and OTC medications, and seek emergency medical treatment including ordering X-rays, routine tests and treatment. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child.

In the event that I cannot be reached in an emergency, I give permission to the physician/health officer selected by the camp to secure and administer treatment, including hospitalization for the person named above. This completed form may be photocopied for off-site camps.

Signature of parent or legal guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Printed name: \_\_\_\_\_ Phone number: \_\_\_\_\_

*The information on this form is kept in strict confidence by Camp Brethren Heights directors, counselors & health officers.*

*Complete both sides of this form; keep a copy for your records. This form may be photocopied.*

*Printable forms and all program information are available at [www.campbrethrenheightsmi.org](http://www.campbrethrenheightsmi.org) or call us at (231) 867-3618.*