



Rose Lake Youth Camp

Camper Health Record

Date of camper arrival: _____ Date of departure: _____

Child's name: _____ Sex: _____ Birth date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Parent/Guardian's name(s): _____

Address (if different from above): _____

If parents/guardian will be at a different location during the week of camp, list below:

Location: _____ Phone: _____

Alternate emergency contact person:

Name: _____ Relationship to child: _____

Home Phone: _____ Cell: _____ Work: _____

Family Physician: _____ Address: _____ Phone: _____

Medications:

List all, including prescriptions and non-prescription medications, currently being given and/or discontinued within the last 3 months. Attach additional sheet if necessary.

Drug _____ Frequency _____ Dosage _____ Purpose _____

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Allergies (including insects, food, drugs, animals or environmental), reaction, (severity, type) and treatment.

Have you ever experienced an Anaphylactic (severe allergic) Reaction? If so, explain:

Any Activity Restrictions because of physical limitations? If yes, please explain conditions of limitations. For example, the conditions that pose potential problems, related restrictions, duration of conditions, requirements to prevent or reserve conditions and warning signs or symptoms: _____

Special Conditions to be watched for (fainting, sleepwalking, recent life changes or loss):

Special Needs (identify any special needs, limitations, and adaptations, and/or assistance needed. Include any special health and/or behavioral considerations, attention difficulties, learning disabilities, prostheses, and/or dietary needs): _____

Do you have or have you had any of the following health problems?

	Yes	No		Yes	No
1. Hay fever, asthma, wheezing, shortness of breath or any breathing difficulties			8. Emotional difficulties		
2. Chronic condition of disease			9. Speech or hearing problems		
3. Convulsions/seizures			10. Dental problems		
4. Heart trouble			11. Special needs		
5. Hypo or Hyperglycemia			12. Infectious diseases		
6. Frequent cold, sore throats, earaches (4 or more a year)			13. Menstrual problems		
7. Urinary or bowel problems			14. Other:		

Please explain any problem area identified above: _____

Operations or injuries: _____

Immunizations

Tetanus – Date of initial immunization: _____ Most recent booster: _____

Childhood diseases

Are the following immunizations up to date? Yes _____ No _____

- Diphtheria, Pertussis, Whooping cough, Polio, Measles, Mumps, Rubella

If no, please explain: _____

Medical Authorization

I/We give our approval for _____ to participate in Rose Lake Youth Camp. I/We agree that the medical history and information provided is accurate and complete and that the child has been informed of any/all conditions and/or restrictions. I/We hereby give permission to Rose Lake You Camp, which is licensed by the state of Michigan, to secure emergency medical and surgical treatment and to provide routine medical care, for the above named individual, while attending camp. I/We will assume responsibility for any necessary medical or hospital expense if such should be needed by him/her. I/We understand that the Rose Lake Youth Camp staff and volunteers in charge will exercise every reasonable precaution to protect the health, safety, and welfare of the entire group at all times.

Signature of authorized person: _____ Date: _____

Health Insurance Information

Insurance Company Name: _____

Telephone: _____ Address: _____

Policy number(s): _____

Policy Holder’s Name: _____ Relationship to camper: _____

Social Security Number: _____ Employer: _____

Address & Telephone (if different from above): _____

Names of person other than the authorized person to whom camper may be released:

1. _____ 3. _____

2. _____ 4. _____

Signature of authorized person: _____ Date: _____