HEALTH FORM 2015

PLEASE PRINT

CAMPER TEAM
ELIJAH STAFF
MEMBER STAFF
KID

Circle Week(s) of Attendance

FAMILY 1 2 HORSE
BUILT 1 2 JR. HORSE
BOYS JR. HIGH/MIDDLE
CILT 1 2 HIGH SCHOOL
GIRLS 1 2 SOAR TRIP
PERFORMING ARTS

- THIS FORM OR A COMPLETED ONLINE HEALTH FORM IS REQUIRED FOR ATTENDANCE.
- BOTH SIDES MUST BE COMPLETED BY PARENT/GUARDIAN OF CAMPERS.
- NO HEALTH EXAM IS REQUIRED. ANNUAL UPDATE REQUIRED.
- USE A SEPARATE SHEET OF PAPER FOR ADDITIONAL REMARKS OR HEALTH ISSUES.
- STAFF AND STAFF CHILDREN MUST ALSO HAVE A COMPLETED HEATLH 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/bulemia
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

List all meds taken, include over the counter, prescription, and vitamins.

All medications and vitamins must be in original containers.

Provide enough for the duration of the campers stay.

Medication Name	Dosage	Time /Frequency Taken	Daily or As Needed

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_____ _____

Signature of parent/guardian or adult camper/staff — Date

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_____ _____

Signature of parent/guardian — Date

INSURANCE

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

Name of Policy Holder _____

Social Security # of Policy Holder _____

Medical Insurance Company _____

Is the plan a: *Circle* HMO PPO

- o Must call for emergency room care
- o Must call prior to local doctor's visit or walk-in clinic

Company Phone Number for approval (_____) _____

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

#s _____

_____

_____

_____

X_____ _____

Signature of parent / guardian — Date

MAIL TO:

Completed form must be at camp before the camper arrives

BEFORE June 10 Mail to:
Huron Forest Camp CedarRidge - 26205 Five Mile Road, Redford, MI 48329
Questions: (248) 470-4432 Metro Office

AFTER June 10 Mail to:
Huron Forest Camp CedarRidge - 1154 W. River Rd, Oscoda, MI 48750
Questions: (989) 739-3571 Camp