Lake Louise Summer Camp

Youth Health Form

Lake Louise Camp
11037 Thumb Lake Road
Boyne Falls, MI 49713
231-549-2728

Attending Lake Louise Camp Session:_______________________________
Camp Name

Camper Name: ____
First Middle Last

☐ Male ☐ Female Birth Date _____________ Age at camp ________
Month/Day/Year

School: ________________________ Church: ________________________

To Parent(s)/Guardian(s): **Please complete all pages of this form and *make a copy!***
Send the *original, signed FORMS* to camp at least 1 month prior to your scheduled camp.
Please keep the copy for your records and bring along to Camp on arrival day.

Camper Home Address: ____
Street Address City State Zip

Parent/Guardian with legal custody to be contacted in case of illness or injury:

Name: _________________________ Relationship to Camper: ______________ Preferred Phones: (_____)_______________(_____)_______________
Email: ____

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

Second Parent/Guardian or other emergency contact:

Name: _________________________ Relationship to Camper: ______________ Preferred Phones: (_____)_______________(_____)_______________
Email: ____

Additional contact in event parent(s)/guardian(s) cannot be reached:

Name: _________________________ Relationship to Camper: ______________ Preferred Phones: (_____)_______________(_____)_______________
Email: ____

Allergies: ☐ No known allergies. ☐ This camper is allergic to: ☐ Food ☐ Medicine ☐ The environment (insect stings, hay fever, etc.) ☐ Other
(***Please describe below what the camper is allergic to and the reaction seen.)***
(If it is a Peanut allergy – is it airborne / tactile or by mouth?)

Diet, Nutrition: ☐ This camper eats a regular diet. ☐ This camper eats a regular vegetarian diet.
☐ This Camper has special food needs. ***(Please describe below.)***

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.)

Parent/Guardian Authorization for Camp Participation:

In consideration for being allowed to participate in the Lake Louise Summer Camp programs, I agree to assume the risk of such activities and programs, and I further agree to hold harmless Lake Louise Christian Community, its officers, employees and representatives from any and all claims, suits, losses, or related causes of action for damages, including, but not limited to, such claims that may result from injury or death, accident or otherwise, during or arising in any way from the activities. I grant permission for me or my child to participate in all planned camp activities including out of camp trips by van, bus or hiking.
I acknowledge that this General Release of Liability and Authorization for Treatment of Lake Louise Christian Community is binding on me personally and on my heirs, personal representatives, successors and assigns. This agreement will be enforced in accordance with the law of the State of Michigan.

Parent/Guardian Authorization for Health Care:

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 and/or examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and 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 to 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 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 camp staff about my child's health status.

Signature of Custodial Parent/Guardian ______________________________________ Date: _______________ Relationship to Camper: ___________________________

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Camper Name: ____
First Middle Last

Birthdate: ____________________ (Month/Day/Year)

Immunization History: Provide the month and year for each immunization. Starred (★) immunizations must be current.

Immunization	Most Recent Dose Month/Year
★ Diptheria, tetanus, pertussis (DTaP) or (TdaP)	
★ Tetanus booster (dT) or (TdaP)	
★ Mumps, measles, rubella (MMR)	
★ Polio (IPV)	
Haemophulus influenza type B (HIB)	
Pneumococcal (PCV)	
Hepatitis B	
Hepatitis A	
Varicella ☐Had Chicken Pox (chicken pox) Date:	
Meningococcal meningitis (MCV4)	

Please ~
Attach a copy of your child's most recent Immunization record.

Tuberculosis (TB) test	Date:	☐ Negative ☐ Positive

If your camper has not been fully immunized, please sign the following statement: **I understand and accept the risks to my child and the other campers from not being fully immunized.**

Signature of Custodial Parent/Guardian: ________________________________ Date: ____________________ Relationship to Camper: ______________________

Medication:

☐ 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. ***Bring enough of each medication to last their entire stay. ALL medications must arrive in the original and appropriately labeled pharmacy containers as described in the "Health Services Parent Information". ALL medications will be turned in to the Camp Health Office upon arrival.***

Name of medication	Date Started	Reason for taking it	When it is given	Amount or dose given	How it is given
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time: ______		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time: ______		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time: ______		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time: ______		

The following non-prescription medications are representative of what may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury.
Cross out those the camper should not be given.

Acetaminophen (Tylenol)
Pseudoephedrine (Sudafed)
Technu Extreme (Poison Ivy skin wash)
Docusate Sodium (Stool softener)
Hydrocortisone Cream
Chloraseptic Spray (Sore throat spray)
Cough Drops
Calagel

Ibuprofen (Advil, Motrin)
Guaifenesin DM (Cough Medicine)
Diphenhydramine (Benadryl)
Loperamide HCL (Anti-Diarrhea)

Tums
Cola Syrup
Aloe Vera Gel

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Camper Name: ____
First Middle Last

Birthdate: ____________________ (Month/Day/Year)

General Health History: Check *"Yes" or* "No" *for each statement. Explain* "Yes" *answers below.*

Has/does the camper:

1. Ever been hospitalized?....................................... ☐ Yes ☐ No
2. Ever had surgery?.. ☐ Yes ☐ No
3. Have recurrent/chronic illnesses?......................... ☐ Yes ☐ No
4. Had a recent infectious disease?.......................... ☐ Yes ☐ No
5. Had a recent injury?... ☐ Yes ☐ No
6. Had asthma/wheezing/shortness of breath?......... ☐ Yes ☐ No
7. Have diabetes?.. ☐ Yes ☐ No
8. Had seizures?.. ☐ Yes ☐ No
9. Had headaches?.. ☐ Yes ☐ No
10. Wear glasses, contacts, or protective eyewear?. . ☐ Yes ☐ No
11. Had fainting or dizziness?.. ☐ Yes ☐ No
12. Passed out/had chest pain during exercise?................................ ☐ Yes ☐ No
13. Had mononucleosis (mono) during the past 12 months?............. ☐ Yes ☐ No
14. If female, have problems with periods/menstruation?.................. ☐ Yes ☐ No
15. Have problems falling asleep/sleepwalking?................................ ☐ Yes ☐ No
16. Ever had back or joint problems?.. ☐ Yes ☐ No
17. Have a history of bedwetting?.. ☐ Yes ☐ No
18. Have problems with diarrhea/constipation?.................................. ☐ Yes ☐ No
19. Have any skin problems?.. ☐ Yes ☐ No
20. Traveled outside the country in the past 9 months?..................... ☐ Yes ☐ No

★The camper will carry an inhaler while at camp............................. ☐ Yes ☐ No
★The camper will carry an Epi-Pen while at camp……………… ….. ☐ Yes ☐ No

Please explain "Yes" answers in the space below, noting the number of the questions and if the camper is currently under treatment for that specific item. For travel outside the country, please name countries visited and dates of travel.

PLEASE NOTE: The Health Center at Lake Louise Camp is not equipped to support all Chronic Illnesses. We expect any camper with a chronic illness to be *Self-Managed.* If you have any questions or concerns relating to your child, please contact our office.

Mental, Emotional, and Social Health: ***Check "Yes" or "No" for each statement.***

Has the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?................................ ☐ Yes ☐ No
2. Ever been diagnosed with Autism Spectrum Disorder?.. ☐ Yes ☐ No
3. Ever been treated for emotional or behavioral difficulties or an eating disorder?.. ☐ Yes ☐ No
4. During the past 12 months, seen a professional to address mental/emotional health concerns?... ☐ Yes ☐ No
5. Had a significant life event that continues to affect the camper's life?.. ☐ Yes ☐ No
   (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

Health-Care Providers:

Name of camper's primary doctor(s): ____ Phone: (_______) ________________________

Name of dentist(s): ____ Phone: (_______) ________________________

Name of orthodontist(s): ____ Phone: (_______) ________________________

What Have We Forgotten to Ask? ***Please provide in the space below*** any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program. ***Attach additional information if needed.***

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Camper Name: ____
First Middle Last

Birthdate: ____________________ (Month/Day/Year)

Medical Insurance Information:

This camper is covered by family medical/hospital insurance: ☐ Yes ☐ No

Include a copy of your insurance card; copy both sides of the card so information is readable.

Insurance Company ___________________________________ Policy Number ___________________________________

Subscriber ____ Insurance Company Phone Number (________) _________________

Lake Louise Summer Camp
★ Health Center Use Only ★

Date	Time	CHO	Notes

FOR CAMP PERSONNEL
Arrival Day Check-In

1. Emergency authorization on page one of this form signed? **YES** **NO**
2. Has any information on the Health Form changed since the date of originally submitting the form to Lake Louise? **YES** **NO**
3. Been exposed to any contagious disease in the last two weeks? (Camper or Family Member) **YES** **NO**

If yes, explain: ____
____

4. Brought over the counter or prescription medications? **YES** **NO**
   Additional medication form needed to list additional meds? **YES** **NO**
   (The Health Officer will need to record all medication brought to camp.)
5. Medical/social/physical condition of which camp staff should be informed? **YES** **NO**

If yes, explain: ____

6. Does your child have any bumps, bruises or burns we need to be aware of? **YES** **NO**

If yes, explain:____

Staff Member's Initial ______________

Information Received from: Mother Father Grandparent Camper Other ____________

Date, if different than registration date ________________