

CAMP WAKANDA HEALTH FORM

Camper's Name _____ Date _____

It is always the goal of the camp leadership team to provide a positive and nurturing experience for all campers. All information on this form will be kept confidential and used only to help us prepare appropriate support and guidance for your child while in the care of staff at Camp Wakanda.

1. Has your child been ill in the last three weeks? Yes No
If yes, please describe:

2. Does your child have any physical disabilities? Yes No
If yes, please describe:

3. Does your child have any emotional, psychiatric or psychological difficulties? Yes No
If yes, please describe:

4. Does your child have any allergies? Yes No
If yes, please describe:

5. Does your child take any medication? Yes No
If yes, please list:

6. Has your child had a tetanus shot? Yes No If yes, when was their last shot? _____

7. Is your child subject to any of the following? (please check any that might apply)

<input type="checkbox"/> Headaches	<input type="checkbox"/> Nightmares	<input type="checkbox"/> Sinus Infections
<input type="checkbox"/> Sleep Talking	<input type="checkbox"/> Motion Sickness	<input type="checkbox"/> Lice (currently)
<input type="checkbox"/> Spasms/Seizures	<input type="checkbox"/> Bedwetting/soiling	<input type="checkbox"/> Sleep Walking
<input type="checkbox"/> Draining Ears	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Constipation
<input type="checkbox"/> Nose Bleeds	<input type="checkbox"/> Fainting	<input type="checkbox"/> Bowel/Bladder Control Issues

If you checked any of the above, please provide additional information, including how we can help (feel free to use the back of the form if needed):

Please turn over.

Is there anything else about your child that you believe would be helpful for us to know?

I understand that to ensure the success of my child at camp, any special needs must be addressed with the Camp Manager and Camp Director prior to the departure of camp. If necessary, an individualized behavior plan will be designed with myself, my child and camp staff.

Signature of Parent/Guardian:

MEDICAL EMERGENCY CARE AUTHORIZATION

Michigan Department of Human Services

Notice: By signing the reverse side of this card you are granting the operator of the camp organization authority to secure emergency medical, surgical treatment for your camper while attending camp if there is insufficient time to contact you. You are giving the camp operator permission to secure routine, non-surgical medical care for your child while attending camp. In accordance with MCLA Act 116 of the Public Acts of 1973 and the rules for licensing children's camps, this authorization must be signed by a parent or guardian unless there is religious objection.

MCLA 722, 124a, Section 14a(2) states: "A parent or guardian of a minor child who voluntarily places the child in a child care organization shall execute a written instrument investing the organization with authority to consent to emergency medical and surgical treatment of the child. The parent or guardian shall consent to routine, non-surgical medical care.

Name of Child (Print Last Name, First Name)

Camp Attending: _____ **T-Shirt Size:** _____

I hereby give permission to the children's camp named below, which is licensed by the Department of Human Services, to secure emergency medical and surgical treatment and to provide routine, non-surgical medical care, for the minor child named above, while attending camp.

Parent/Guardian Signature

Date

Parent/Guardian Signature

Date

Camp Name: Allen Park Presbyterian Church-Camp Wakanda

The Department of Human Resources (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your county.

OCAL-3978 (Rev. 4-05) Previous edition may be used. MS Word

MEDICAL INSURANCE INFORMATION

Family Physician is _____ **Phone** _____

Insurance Carrier is _____

Policy Number is _____

Name of Policy Holder is _____

Verification Phone Number is _____

YES I want my child's medication(s) administered in private.

NO I do not need my child's medication(s) administered in private.

HEALTH HISTORY RECORD

Michigan Department of Human Services

Dear Authorized Person:

The following information is request so that the Camp can better meet the physical, intellectual, and emotional needs of the camper. Fill out the information requested. (Use back of form if additional space is required.) "Authorized person" means a parent, guardian, or adult camper's designee.

Camper's Name (Last)		First		Middle	Sex	Date of Birth
Address (Number and Street)			City		Zip	Telephone (Home)
Authorized Person's Name (Last)		First		Middle	Telephone (Work)	
Address (Number and Street)			City		Zip	Telephone (Emergency)
Is the camper having any of the problems listed below?				Yes	No	
1.	Hay fever, asthma, or wheezing		<input type="checkbox"/>	<input type="checkbox"/>	7.	Trouble with passing urine or bowel movements
2.	Eczema or frequent skin rashes		<input type="checkbox"/>	<input type="checkbox"/>	8.	Shortness of breath
3.	Convulsions/seizures		<input type="checkbox"/>	<input type="checkbox"/>	9.	Speech problems
4.	Heart Trouble		<input type="checkbox"/>	<input type="checkbox"/>	10.	Menstrual Problems
5.	Diabetes		<input type="checkbox"/>	<input type="checkbox"/>	11.	Dental problems
6.	Frequent colds, sore, throats, ear aches (4 or more per Year)		<input type="checkbox"/>	<input type="checkbox"/>	12.	Other
						<input type="checkbox"/> Yes <input type="checkbox"/> No

Please explain any problem areas identified above including any current infectious diseases:

If female has she been told about menstruation (answer if appropriate) <input type="checkbox"/> Yes <input type="checkbox"/> No	Has she menstruated (answer if appropriate) <input type="checkbox"/> Yes <input type="checkbox"/> No
--	---

Operations or Injuries

Explain Any Special Health, Behavioral or Emotional Consideration(s)

Medication Needed or Used (Including Psychiatric)			Currently Being Given	
Kind	Frequency	Dosage	<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No

Special conditions to be watched for such as ALLERGY (Reactions to food, Penicillin or other drugs), Bedwetting, Fainting, Sleep Walking, etc.

IMMUNIZATION		Polio	Mumps	Diphtheria	Tetanus	Pertussis (Whooping cough)	Measles	Rubella	Hepatitis B	Other
	Date Initial Immunization Completed									
	Date of Most Recent Booster									

Should the camper's activity be restricted because of any physical limitation or illness? No Yes If yes, explain degree of restriction:

I certify that this information is true to the best of my knowledge.	Authorized Person's Signature	Date
--	-------------------------------	------

The Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your county.

STATE OF MICHIGAN

Camper Records RULE 117 (2)
Parent or Guardian Authorization Form

IMPORTANT!

Authorizations:

My child has permission to engage in all prescribed camp activities, except as noted by me or an examining physician.

In case of injury, parents or the emergency contact person will be called immediately for their decision on medical treatment.

If parents or the emergency contact person is not available, we will use our best judgment as to what course of action to pursue and will continue to attempt contact. The camp or our organization will not be responsible for any costs incurred as a result of illness or injury. Parents should notify camp if this camper is exposed to any communicable disease during the three weeks prior to camp attendance.

I understand my child will be sent home if their behavior jeopardizes the other participants, jeopardizes the integrity of the program, or is not viewed as appropriate in anyway by the group leadership.

I understand my child may be participating in camp activities that **may** include Technical Tree Climbing, Horseback Riding, Boating, and Archery. I understand that there may be inherent risks in these activities.

If my child must return home due to illness or behavior, I will incur the cost of transporting them home or I will arrange transportation for my child within a realistic time specified by the group leadership.

I also give my permission for my child to be photographed or videotaped and allow our group to release said pictures for publicity purposes.

In the event that I am not able to pick up my child, she (he) may be released only to the following people:

Signed: _____ Relationship: _____ Date: _____