Howell Conference and Nature Center

Permission slip and Health History Form for Campers

To be completed by parent or guardian

Dates and name of camp Attending ______________________________

Name______________________________ Birth date ____________ Age at Camp ________
Last First Middle

Home address ______________________________
Street address City State Zip

Gender: Male Female

Custodial parent/guardian ____________________ Phone ____________________

Place of work ______________ Phone ______________ Personal Cell Number ______________

Emergency contacts ______________________________
Name Phone Relationship

Address ______________________________
Street address City State zip

If not available in an emergency, notify ______________________________
Name Phone Relationship

Address______________________________
Street address City State Zip

Insurance Information

Is the participant covered by family medical/hospital insurance? Yes No Policy holder's name ______________

Carrier or plan name ____________________ Policy # ____________________

▶ Photocopy of front and back of health insurance card should be attached to this form.

Name of family physician ____________________ Phone ____________________

Address ______________________________
Street address City State zip

Important ---- This box must be complete for attendance

Parent/Guardian Authorizations: I give permission for my child to attend the Howell Nature Center camps. This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted. I give permission for the camp First Aid personnel to provide routine health care, administer prescribed medications, and fist aid treatment on site. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for my child, in the event I cannot be reached in an emergency. I give permission to the physician or the aforementioned camp First Aid personnel to hospitalize secure proper and/or routine treatment and to order injection, anesthesia, x rays, or surgery for my child in the event I cannot be reached in an emergency. This completed form may be photocopied for trips out of camp.

I give permission for my child to be interviewed and pictures taken to be used by the Howell Nature Center or other news media to help with the promotion of the Howell Nature Center camps or related events.

______________________________ Date ____________________
(Signature of parent or guardian)

______________________________ Date ____________________
(Signature of parent or guardian)

Restrictions (The following restrictions apply to this individual.) **Does not eat:** Red meat Pork Dairy products Poultry Seafood Eggs Other ______________

Health History

Allergies List all know. Describe reaction and management of the reaction

Medication allergies (list) ____ **Food** _____________________________________

___________________________________ **Other (insect stings asthma, animal)** ____

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Medications Being Taken **This person takes NO medications on a routine basis.**

Please list all medications (including over- the- counter of nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (If prescription drug), the name of the medication, the dosage, and the frequency of administration.

This person takes medications as follows:

Medication	**Dosage**	**Hours given**	**Reason**

I hereby give permission to administer the over-the-counter medications listed below, or their generic equivalents EXCEPT THOSE I HAVE CROSSED OUT if the Camp Health officers deem it necessary. Dosages will be administered according to directions on the bottle unless a physician directs otherwise.

Tylenol	Benadryl	Cough drops	Tums	Pepto Bismol	Robitussin
Motrin	Contac	Eye drops	Aloe Cream	Caladryl lotion	Hydrocortisone cream

General Questions (Explain "yes" answers below)

Has/does the participant:	**Yes**	**No**		**Yes**	**No**
1. Had any recent injury or illness or infectious disease?	___	___	2. Ever been hospitalized?	___	___
3. Have a chronic or recurring illness/condition?	___	___	4. Ever had surgery?	___	___
5. Have frequent headaches?	___	___	6. Ever had a head injury?	___	___
7. Ever been knocked unconscious?	___	___	8. Wear glasses, contacts or protective eye wear?	___	___
9. Ever have frequent ear infections?	___	___	10. Ever have seizures?	___	___
11. Ever been diagnosed with a heart murmur?	___	___	12. Ever had back problems?	___	___
13. Have any skin problems? (itching, rash, acne)?	___	___	14. Have diabetes?	___	___
15. Have asthma?	___	___	16. Have a history of bed-wetting?	___	___

Please explain any yes answers, noting the number of the questions. ____

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Which of the following has the participant had? Measles Chicken pox Mumps German measles Hepatitis A or B or C

Screening Record (For camp use only) Screened by____

Date screened ___________ Time _______________ Meds received ____

Current health needs identified____

Observational notes ____

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