# HEALTH HISTORY & RELEASE FORM

Date and Name of Camp Attending

| Camper Name | DOB | Gender | Height | Weight |
|---|---|---|---|---|
| Home Address | City | | State | Zip |

Custodial Parents/Guardians

| Home/Cell Phone | Email Address | |
|---|---|---|
| Emergency Contact | Relationship | Phone |

## INSURANCE INFORMATION

Is this child covered by family medical/hospital insurance? ❍ Yes ❍ No

| Policyholder's Name | Carrier or Plan Name | Policy # |
|---|---|---|
| Name of Family Physician | Phone | |

## EMERGENCY MEDICATIONS

Does your child require the following? ❍ EpiPen ❍ Rescue Inhaler ❍ Other

If yes, please describe _____

## ALLERGIES AND DIETARY RESTRICTIONS

Does your child have any of the following allergies? ❍ Food ❍ Drug/Medicine ❍ Environmental (Stings, Bites) ❍ No Known Allergies

If yes, please describe allergic reaction details, dates, etc. _____

Does your child have any dietary restrictions? ❍ Yes ❍ No

If yes, please describe _____

## IMMUNIZATIONS

My child's vaccinations are up to date/current. ❍ Yes ❍ No _____ Please Initial _____ Date

## WHICH OF THE FOLLOWING HAS THE CAMPER HAD?

❍ Measles ❍ Chicken Pox ❍ Mumps ❍ German Measles ❍ Hepatitis A or B or C ❍ Mono (Past Year)

## DOES YOUR CHILD HAVE ANY RESTRICTION ON ACTIVITY? ❍ Yes ❍ No

If yes, please describe _____

## DOES YOUR CHILD REQUIRE ANY SPECIAL ASSISTANCE WHILE AT CAMP? ❍ Yes ❍ No

If yes, please describe _____

## MEDICATIONS BEING TAKEN

❍ This child takes no medication on a routine basis.

Please list all medications (including over-the-counter, non-prescription 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.

| MEDICATION | DOSAGE | TIMES | REASON |
|---|---|---|---|
| | | ❍ Breakfast ❍ Lunch ❍ Dinner ❍ Bedtime ❍ Other | |
| | | ❍ Breakfast ❍ Lunch ❍ Dinner ❍ Bedtime ❍ Other | |
| | | ❍ Breakfast ❍ Lunch ❍ Dinner ❍ Bedtime ❍ Other | |
| | | ❍ Breakfast ❍ Lunch ❍ Dinner ❍ Bedtime ❍ Other | |
| | | ❍ Breakfast ❍ Lunch ❍ Dinner ❍ Bedtime ❍ Other | |

## OVER-THE-COUNTER MEDICATIONS

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

**OR** Please cross out (X) any medication that your child cannot take.

Acetaminophen Antacids Antibiotic Creams Antihistamines Calamine Lotion Eye Drops Hydrocortisone Cream

Ibuprofen Insect Repellent Pepto-Bismol Sunburn Spray/Cream (Solarcaine) Sunscreen

## HEALTH HISTORY

| | | | | | |
|---|---|---|---|---|---|
| Asthma/Inhaler | ❍ Yes ❍ No | Eating Disorder | ❍ Yes ❍ No | Respiratory Ailments | ❍ Yes ❍ No |
| Back Pain | ❍ Yes ❍ No | Epilepsy | ❍ Yes ❍ No | Seizures | ❍ Yes ❍ No |
| History of Bedwetting | ❍ Yes ❍ No | Hay Fever | ❍ Yes ❍ No | Sinus Infections | ❍ Yes ❍ No |
| Behavioral Issues | ❍ Yes ❍ No | Headaches | ❍ Yes ❍ No | Skin Problems | ❍ Yes ❍ No |
| Bleeding Disorder | ❍ Yes ❍ No | Hearing Problems | ❍ Yes ❍ No | Sore Throats | ❍ Yes ❍ No |
| Cancer | ❍ Yes ❍ No | Hernia | ❍ Yes ❍ No | Speech Problems | ❍ Yes ❍ No |
| Constipation/Diarrhea | ❍ Yes ❍ No | Homesickness | ❍ Yes ❍ No | Stomach Aches | ❍ Yes ❍ No |
| Depression | ❍ Yes ❍ No | Irritable Bowel Syndrome | ❍ Yes ❍ No | Urinary Tract Infections | ❍ Yes ❍ No |
| Developmental Delays | ❍ Yes ❍ No | Lice | ❍ Yes ❍ No | Uses Eye Glasses/Contacts | ❍ Yes ❍ No |
| Diabetes | ❍ Yes ❍ No | Mental Health Issues | ❍ Yes ❍ No | Visual Problems | ❍ Yes ❍ No |
| Down Syndrome | ❍ Yes ❍ No | Motion Sickness | ❍ Yes ❍ No | Other | ❍ Yes ❍ No |
| Ear Infections | ❍ Yes ❍ No | Pneumonia | ❍ Yes ❍ No | | |

If yes, please describe _____

_____

## WHAT HAVE WE FORGOTTEN TO ASK?

Please use the space below (attach any extra notes) to provide us with any information that will help your camper be successful while they're at camp. This can include information pertaining to their social behavior, physical needs or emotional habits. Do they need an aide in school, are they shy, do they need to be reminded to use the restroom, etc. Any information that may affect their participation in camp programs and potential accommodations are useful. _____

_____

## PARENT/GUARDIAN AUTHORIZATIONS

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 first aid treatment on site. I hereby give permission for Howell Nature Center (HNC) staff to administer the medication provided and listed on this form to my child. 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 understand that HNC may take certain reasonable recording of this camping event. I hereby authorize HNC to have and use reasonable photographs, video and audio/video records of my child for purposes of legitimate HNC records, public relations and/or advertising.

_____

Signature of Parent or Guardian Date

_____

Signature of Parent or Guardian Date

1005 Triangle Lake Road | Howell, MI 48843 | **(517) 546-0249** | **howellnaturecenter.org**

Howell Nature Center

Heal. Grow. Be Wild!