CAMPER MEDICAL EXAM FORM

MUST BE COMPLETED AND SIGNED BY A PHYSICIAN FOR ATTENDANCE.

PLEASE ATTACH A COMPLETE IMMUNIZATION HISTORY

Please Mail *by* May 4, 2019 to:
Summer Impressions Day Camp
4150 Middlebelt Road
West Bloomfield, MI 48323
248-932-2955
or
Fax to: 248-932-5893
or
Scan and email to:
info@summerimpressions.com

Medical Personnel: Please complete all sections of this form and attach immunization history. Attach additional information as needed.

Last Name_____ First Name_____

Date of Physical Exam:_____ Weight_____lbs. Height _____ft. _____in.

Blood Pressure_____/_____ Pulse_____

A physical exam to have been performed within two (2) years of the camper's FIRST DAY OF CAMP.

ALLERGIES ____No known allergies.
____This camper is allergic to:____Food ___Medicine ___Environmental(insect stings, pollen, etc.) ___Other

Please describe below what the camper is allergic to and the reaction seen.

TREATMENTS

The camper is undergoing treatment at this time for the following conditions (including emotional/psychological):

_____NONE

MEDICATION

The camper will take the following prescribed medication(s) while at camp: (name, dose, frequency)

_____None

RESTRICTIONS

Do you feel that the camper will require limitations or restrictions to activity while at camp? ___Yes ___No
If you answered "Yes"* to the question above, what do you recommend? *(Attach additional information if needed)

IMMUNIZATION HISTORY

Please attach a copy of the above child's immunization history from a health-care provider or state and/or local government.

****A complete immunization history from a health care provider or state and/or local government documenting all age appropriate vaccinations is required before attendance at camp. If you have any questions, please call 248-932-2955****

I have examined the above applicant for entrance to Summer Impressions Day Camp and find him/her physically qualified to be accepted as a camper and to participate in all camp activities, except as noted above.

Physician's Name_____Signature_____Date_____
Address:_____Phone Number_____
City_____State_____Zip Code_____

CAMPER HEALTH HISTORY FORM

MUST BE COMPLETED AND SIGNED BY A PARENT/GUARDIAN FOR ATTENDANCE.

CAMPER NAME _____ Birthdate_____

Camper Home Address_____

Street City State Zip Code

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

Name_____ Relationship to Camper_____ Preferred Phones (_____)_____ (____)_____

EMAIL _____

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 (_____)_____ (____)_____

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

Has/does the camper:

Ever been hospitalized?	Yes	No	Had Fainting or dizziness?	Yes	No
Ever had surgery?	Yes	No	Passed out/had chest pain during exercise?	Yes	No
Have recurrent/chronic illnesses?	Yes	No	Had mononucleosis ("Mono") during the last 12 months?	Yes	No
Had a recent infectious disease	Yes	No	If female, have problems with periods/menstruation?	Yes	No
Had a recent injury?	Yes	No	Have problems with falling asleep/sleepwalking?	Yes	No
Had asthma/wheezing/shortness of breath?	Yes	No	Ever had back/joint problems?	Yes	No
Have diabetes?	Yes	No	Have a history of bedwetting?	Yes	No
Had seizures?	Yes	No	Have problems with diarrhea/constipation?	Yes	No
Had headaches?	Yes	No	Have any skin problems?	Yes	No
Wear glasses, contacts, or protective eyewear?	Yes	No	Traveled outside the country in the past 9 months?	Yes	No

Please explain "Yes" answers in the space below. For travel outside of the country, please name the countries visited and dates of travel.

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

Has the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (ADHD)? Yes No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder? Yes No
3. During the past 12 months, seen a professional to address mental/emotional health concerns? Yes No

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

Medical Insurance Information:

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

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

Insurance Company_____ Policy Number_____

Subscriber_____ Insurance Company Phone Number _____

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 an examining physician. I give permission to the physician selected by the camp to order ex-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 five 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 program's staff about my child's health status.

Signature of Custodial Parent/Guardian_____Date_____

If for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.