BATAWAGAMA

IRON COUNTY YOUTH CAMP

909 PENTOGA TRAIL | CRYSTAL FALLS, MI 49920 | P: 906-265-4476

CAMPER HEALTH EXAMINATION RECORD

TO BE COMPLETED BY PARENT OR GUARDIAN

_____[____]_____/____/____

1. NAME: LAST – FIRST – MIDDLE 2. SEX 3. DATE OF BIRTH

_____

4. STREET ADDRESS CITY STATE ZIP

_____

5. NAME OF PARENT OR GUARDIAN

6. HOME PHONE #_____ CELL PHONE#_____

WORK PHONE#_____ EMERGENCY#_____

_____

7. PARENT OR GUARDIAN: STREET ADDRESS CITY STATE ZIP

_____

8. SPECIAL CONDITIONS SUCH AS: ALLERGIES, BED WETTING, FAINTING, SLEEPWALKING, ETC.

_____/_____ _____

9. GLASSES NEEDED GLASSES WORN 10. LIST ANY PHYSICAL LIMITATIONS

_____

11. LIST ANY SPECIAL HEALTH OR BEHAVIORAL CONDITIONS

12. LIST ALL CURRENT PRESCRIBED MEDICATIONS (INCLUDING PSYCHIATRIC MEDICATIONS) & INCLUDE EVEN THOSE MEDICATIONS NOT ADMINISTERED AT CAMP.

NAME OF MEDICATION	REASON	DOSAGE

13. BRING ONLY THE EXACT QUANTITY OF MEDICATION NEEDED FOR THE WEEK AT CAMP.

14. ALL MEDICATIONS MUST BE GIVEN TO THE CAMP HEALTH OFFICER AT REGISTRATION TIME AND BE IN A CLEAR ZIP-LOCK BAG WITH THE CAMPER'S NAME ON THE OUTSIDE OF THE BAG.

15. ALL MEDICATIONS MUST BE IN THEIR ORIGINAL CONTAINER WITH THE ORIGINAL DIRECTIONS.

16. ALL MEDICATIONS WILL BE KEPT IN THE DISPENSARY AND DISPENSED ONLY BY HEALTH OFFICER. COMMON OVER THE COUNTER MEDICATIONS ARE AVAILABLE IN THE DISPENSARY FOR CAMPERS.

17. PERSONAL HISTORY (CHECK & GIVE THE APPROXIMATE AGE WHICH CONDITION OCCURRED.)

	X	AGE		X	AGE		X	AGE
ALLERGIES			KIDNEY TROUBLE			SCARLET FEVER		
APPENDICITIS			MEASLES/REGULAR			TONSILLITIS		
ASTHMA			MEASLES/GERMAN			TUBERCULOSIS		
CHICKENPOX			MUMPS			TYPHOID FEVER		
DIABETES			PNEUMONIA			WHOOPING COUGH		
DIPHTHERIA			POLIOMYELITIS			OTHER		
EPILEPSY			RHEUMATIC FEVER					
HEART TROUBLE								

18. IMMUNIZATIONS: (PLEASE LIST THE DATES OF COMPLETION AND/OR DATE OF LAST BOOSTER)

	DATE		DATE		DATE
HEP. B		D.T.		MEASLES	
RUBELLA		TETANUS		MUMPS	

19. SURGERIES: _____

20. HISTORY OF MENTAL ILLNESS: _____

21. LIST ANY INFECTIOUS DISEASES THAT ARE CURRENT OR THAT THE CAMPER HAS BEEN EXPOSED TO WITHIN 3 WEEKS PRIOR TO YOUR STAY AT CAMP: MUST INFORM CAMP OFFICE PRIOR TO ENROLLMENT

_____/_____/_____

NAME OF DISEASE DATE ACQUIRED CURRENT STATUS

22. NAME OF FAMILY PHYSICIAN: _____OFFICE PHONE #_____

ADDRESS:_____HOME PHONE #_____

23. I AUTHORIZE THE IRON COUNTY YOUTH CAMP TO CONSENT TO EMERGENCY MEDICAL TREATMENT OF THE CAMPER, NAMED ON THIS HEALTH FORM INCLUDING ROUTINE CARE AND THE DISPENSING OF PRESCRIPTION MEDICATIONS AS DIRECTED AND OVER THE COUNTER MEDICATIONS AS DIRECTED.

(OVER THE COUNTER MEDICATIONS AVAILABLE AT CAMP ARE AS FOLLOWS: IBUPROFEN, ACETAMINOPHEN, BENADRYL, PSEUDOEPHEDRINE, ANTIHISTAMINE, NAPROXEN, RANITIDINE, TUMS, COUGH DROPS, CALAMINE LOTION, HYDROCORTISONE 1% CREAM, TRIPLE ANTIBIOTIC OINTMENT, SOLARCAINE, & EUCERIN CREAM.) PLEASE LIST ANY OF THESE OVER THE COUNTER MEDICATIONS THAT CANNOT BE ADMINISTERED TO YOUR CHILD:

_____

_____

SIGNATURE OF PARENT OR GUARDIAN

REVISED: 2018