

Please remember to fill this **2-page** form out for **each** child registering with the Children's program.

## MEDICAL HISTORY RECORD

Dear Authorized Person:

The following information is requested so that Simpson Park Camp can better meet the physical, intellectual, and emotional needs of the camper. Fill out the information requested. "Authorized person" means a parent, guardian, or adult camper's designee.

Camper's Name (Last)	First	Middle	Sex	Date of Birth
Address		City	ST	Zip
Home Phone				
Authorized Person's Name (Last)	First	Middle	Work Phone	
Address		City	ST	Zip
Emergency Phone				

Is the camper having any of the problems listed below?	YES	NO		YES	NO
1. Hay fever, asthma, or wheezing			7. Trouble with passing urine or bowel movements		
2. Eczema or frequent skin rashes			8. Shortness of breath		
3. Convulsions/seizures			9. Speech problems		
4. Heart trouble			10. Menstrual problems		
5. Diabetes			11. Dental problems		
6. Frequent colds, sore throats, ear aches (4 or more per year)			12. Other		

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

If female, has she been told about menstruation (answer if appropriate)  
 YES     NO

Has she menstruated (answer if appropriate)  
 YES     NO

Operations or injuries

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

### MEDICATIONS NEEDED OR USED (Including Psychiatric and non-prescription medications)

Name	Dosage	Frequency	Currently Being Given
			<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.

## MEDICAL HISTORY RECORD (cont'd)

As you complete the Immunization section, write in the **date** of the immunization(s) in the appropriate box. The words, "*Up to Date*", are not acceptable.

IMMUNIZATIONS									
	Chicken Pox	Polio IPV/OPV	MMR	Diphtheria, Tetanus, Pertussis DtaP/DTP/DT/Td	HIB Haemophilus influenza type B	Varicella	Rotavirus	Hepatitis B HBV	Other
Date Initial Immunization Completed									
Date of Additional Doses									
Date of Additional Doses									
Date of Additional Doses									
Date of Additional Doses									

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

Insurance Company Name: \_\_\_\_\_

Contract/Policy #: \_\_\_\_\_

Group/Plan #: \_\_\_\_\_

Name of Family Physician: \_\_\_\_\_

Phone #: \_\_\_\_\_ Alt. Phone # (if applicable): \_\_\_\_\_

**PERSON OTHER THAN PARENT/GUARDIAN TO BE NOTIFIED IN AN EMERGENCY SITUATION WHEN PARENT/GUARDIAN IS NOT AVAILABLE:**

Name (Last)	First	Middle	Work Phone	
Address		City	ST	Zip
				Emergency Phone

I give permission to Simpson Park Camp, which is licensed by the Michigan Department of Social Services, medical staff and their designees' to obtain routine, non-surgical medical care, and to secure emergency medical and surgical treatment for my child during the SPC sponsored event, in the event that I am unable to be contacted. I recognize that I am financially responsible for any medical care my child may be required to receive, which my insurance does not cover.

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