

MINIWANCA HEALTH HISTORY 2011

TO BE COMPLETED BY PARENT/GUARDIAN

****FOR OFFICE USE ONLY****

Pre-Season reviewed by _____ Date _____

Health Officer reviewed _____ Date _____

*Please verify contact information above and
make any necessary changes.*

INSTRUCTIONS: Please answer all questions thoroughly. This information is important for the participant's safety. You should know that over the years, many participants with a variety of medical/psychological difficulties have successfully completed our programs, but we must be aware of these conditions. Please provide all information that will ensure the participant receives quality care.

INSURANCE INFORMATION

AYF must receive a copy of participant's insurance card. Please attach a photocopy of your child's primary insurance card to this form. Any co-pays or medical treatment not covered by his/her policy will be billed to the family. ****If uninsured or without a copy of the insurance card, all medical expenses will be the responsibility of the family.**

Insurance Company: _____ Phone Number: _____

Employer: _____ Policy Number: _____

Employee (carrier): _____ Group Number: _____

PERMISSION TO TREAT ****Health History Form is not valid without applicable signatures below.**

I give permission to the AYF/Miniwanca and their staff or designated personnel to treat the above mentioned participant for routine medical procedures, including the dispensing of over the counter medications and to treat the participant in the case of emergency situations or hospitalizations including surgical procedures. I have completely answered all of the questions on this form and have provided complete medical information relevant to the proper care and treatment of the participant. I understand the omission of information can jeopardize the participant's health and overall program experience. I give permission to the Health Center Staff to share the minimum necessary information related to the physical and mental health of the above participant with appropriate AYF/Miniwanca staff, and if necessary with medical providers and/or emergency personnel, as she/he determines is necessary for participant's health and safety. I expect that information shared will be respected as confidential by AYF/Miniwanca personnel.

SIGNATURE of Parent or Legal Guardian: _____ **Date:** _____

Important Information Regarding Physical Examinations and the Health Memorandum Form

All campers must have had a physical examination within 24 months of the camp session. The Health Memorandum Form must be completed and submitted for the camper each year. Though it must be completed by a physician, it does not require a camper to receive a physical examination as long as the camper's last physical exam took place after July 29, 2009. It can be completed with information gathered in the last physical and must be signed by the physician.

Please complete and mail all forms no later than April 15, 2011 to:

Camp Miniwanca, Registrar, 8845 W. Garfield Road, Shelby, MI 49455

HEALTH HISTORY FORM

Has the participant experienced any of the following on this page? If so, please provide a checkmark.

Please consider current and past conditions. If you check any of the items below, please reference the number and explain on page 3.

Allergy to Bee Stings? _____

Allergy to Medications? _____

Epi-pen required? Yes _____ No _____

Other Allergic Reactions (food, foreign proteins, etc.) _____

If yes, explain _____

1 Arthritis..... _____ 2 Asthma..... _____ 3 Back Condition..... _____ 4 Balance Problems..... _____ 5 Bed Wetting..... _____ 6 Blood Disorder..... _____ 7 Bowel/Bladder Control Problems _____ 8 Broken Bones..... _____ 9 Bronchitis..... _____ 10 Chicken Pox..... _____ 11 Circulation Problems..... _____ 12 Constipation..... _____ 13 Development Disability..... _____ 14 Diabetes..... _____	15 Diarrhea..... _____ 16 Digestive Disorders..... _____ 17 Dizziness associated w/exercise _____ 18 Ear Infections..... _____ 19 Epilepsy..... _____ 20 Fainting Spells..... _____ 21 Frequent Colds and Sore Throat _____ 22 Head Injury/Concussions..... _____ 23 Headaches/ Migraines..... _____ 24 Heart Disease/Irregularity..... _____ 25 Heat Stroke..... _____ 26 Hemophilia..... _____ 27 Hypertension..... _____ 28 Hypo/Hyperglycemia..... _____	29 Kidney Problems..... _____ 30 Learning Disability _____ 31 Lung Disease..... _____ 32 Menstrual Abnormalities _____ 33 Nightmares..... _____ 34 Rheumatic Fever..... _____ 35 Seizures..... _____ 36 Skin Problems..... _____ 37 Sleep Talking..... _____ 38 Sleep Walking..... _____ 39 Stomach Upsets/Ulcers.. _____ 40 Strokes..... _____ 41 Surgeries..... _____ 42 Other: _____
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	Has/does the participant:	YES	NO	If you checked yes, please explain below (additional space on page 3)
43	Been treated or hospitalized in past 24 months?			
44	Have any chronic illness?			
45	Have any mobility impairment?			
46	Have any sensory, physical, or cognitive disabilities?			
47	Have any dietary restrictions?			
48	Wear glasses or contact lenses?			
49	Have a medical or dental appliance?			
50	Currently or recently used tobacco, drugs, alcohol?			

Print Camper's Name: _____

If you checked or answered **YES** to any of the items on page 2, please explain below. Include the following information:

- Specific symptoms that are occurring? • How long symptoms / condition lasts? • Date of last occurrence?

- How symptoms / condition affects activity in any way, including ability to run, lift, and climb?

IMMUNIZATION STATUS

For All Participants:

Does participant currently have any infectious diseases? Yes No If yes, explain: _____

Please attach a copy of immunization record if camper is new, or if a returning camper has received updates.

MEDICATIONS **New for 2011**

Daily medication information must be submitted to CampRx 30 days prior to camp opening.

Please list **all** current medications

Medication Name	Dosage	Times	Start Date	Purpose	Special Instructions / Current Side Effects

Please Note: If participant has an allergy requiring an epi-pen, and/or asthma requiring an inhaler, he/she must bring **2 epi-pens and/or 2 inhalers**. One can be carried on participant's person at all times and one will remain in the Health Center as back up.

HEALTH HISTORY FORM

EMOTIONAL and BEHAVIORAL INFORMATION

It is critical for AYF/Miniwanca staff to have accurate and thorough information in this section. We have found this information is vital in impacting the overall experience of the participant.

Does the participant NOW or HAS PARTICIPANT EVER experienced any emotional and/or behavioral disorders? Yes No

If yes, in what area?

- ADD/ADHD
- Anxiety Disorder
- Bipolar Disorder
- Depression
- Substance Abuse
- Other _____
- Obsessive/Compulsive Behavior
- Eating Disorders

Has the participant been OR is he/she currently in counseling with a psychiatrist, psychologist, guidance counselor, or other counselor?

Yes No

If yes, please describe the counseling/therapy/treatments (additional space provided below): _____

Additional comments on health information:
