HEALTH FORM IS DUE ONE WEEK PRIOR TO START DATE OF CAMP SESSION

The ENTIRE Mikell Health Form, including the Healthcare Recommendations by Licensed Medical Personnel (LMP) page, must be completed and returned to Camp EVERY YEAR.

A completed Health Form, including Licensed Medical Provider signature, is REQUIRED for each camper/counselor.

Name: _____
Last First Middle Goes by

Address: _____
Street City State Zip Code

Home Phone: _____ Date of Birth: _____ Age: _____

Gender: ☐ Male ☐ Female

Custodial Parent/Guardian: _____

Phone: Home: _____ Business: _____ Cell: _____

Address: ☐ Same as camper/counselor (see above)

_____
Street City State Zip Code

Additional Emergency Contact: _____ Phone: _____

Insurance Information

Is the camper covered by family medical/hospital insurance? ☐ Yes ☐ No

Insurance Company: _____ Member ID: _____

PLEASE ATTACH A COPY OF BOTH SIDES OF YOUR HEALTH INSURANCE CARD

Parent/Guardian Authorization: The camper listed on this form has permission to engage in all camp activities except as noted. I hereby give permission for necessary health care for my child, as needed. I understand that I will be notified if my child has an illness or injury requiring a visit to a physician, or if he/she is incapacitated for more than 24 hours.

I have supplied complete and accurate health information related to the camper or staff participation in specific activities.

I hereby give permission for any certified/licensed emergency health personnel and/or physicians to treat my child, including hospitalization, for the person named above, and I give permission for Anna C. Dinwiddie or other authorized Mikell personnel to sign forms and give permission for emergency medical care.

Signature of parent/guardian: _____

Printed Name: _____ Date: _____

List and explain any restrictions to activities: _____

Camper/Counselor's Last Name: _____ Session: _____

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Health History

The camper's legal guardian or physician must fill out the following so, we can be aware of any needs.

Allergies: ☐ None

Medications: _____

Food: _____

Other (Insect, Latex, Seasonal, etc.): _____

Medications: ☐ None (including over the counter medications)

☐ The camper takes the following medications:

Medication Name	Dosage	Frequency	Reason for Taking

Please indicate which of the following over the counter medications may be administered by our camp nurse, if needed:

☐ Acetaminophen ☐ Sinus Medications ☐ Antacids

☐ Ibuprofen ☐ Pepto Bismal ☐ Cough Medicine

☐ Benadryl ☐ Kaopectate ☐ Antibiotic Cream

Please list any contraindications or concerns about over the counter medications: _____

_____

Dietary:

Please list any dietary restrictions/needs: _____

_____

Has the camper:

Had a recent injury, illness, or infectious disease? ☐ No ☐ Yes, _____

Ever had a chronic or recurring illness/condition? ☐ No ☐ Yes, _____

Been hospitalized? ☐ No ☐ Yes, _____

Ever had surgery? ☐ No ☐ Yes, _____

Had behavioral issues? ☐ No ☐ Yes, _____

Further explanation of above: _____

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Please use this space to explain any additional information regarding the physical, emotional, or mental health of the camper about which the camp should be aware.

Immunization Record: ☐ See attached form

Vaccine	Month/Year	Month/Year	Month/Year	Month/Year	Month/Year	Month/Year
DTP						
TD (tetanus/diphtheria)						
Tetanus						
Polio						
MMR						
Or Measles						
Or Mumps						
Or Rubella						
Haemophilus influenza B						
Hepatitis B						
Varicella (chicken pox)						

The camper has had:

☐ Measles ☐ Chicken Pox ☐ German Measles ☐ Mumps

☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C

Name of pediatrician/family physician: _____

Address: _____
Street City State Zip Code

Phone: _____

Name of family dentist/orthodontist: _____

Address: _____
Street City State Zip Code

Phone: _____

For Mikell Use Only:

Medications Received: ☐ See MAR

Additional Notes:

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HEALTHCARE RECOMMENDATIONS by LICENSED MEDICAL PERSONNEL

REQUIRED EVERY YEAR

I examined _____ on _____.
Camper/Counselor's Name Date

Date of Birth: _____ BP: _____ Weight: _____ Height: _____

In my opinion, the above individual ☐ is ☐ is not able to participate in an active camp program.

This individual is under the care of a physician for the following conditions: _____

_____

Recommendations/Restrictions for Camp:

Treatment to be continued at camp: _____

_____

Medications to be administered at camp: ☐ None ☐ As listed below

Medication Name	Dosage	Frequency	Other Instructions

Any medically-prescribed meal plans or dietary restrictions: _____

_____

Description of any limitations or restrictions on camp activities: _____

_____

Additional information for healthcare staff at the camp: _____

_____

Allergies: ☐ No known Medications: _____

Food: _____

Other: _____

Signature of LMP: _____ Date: _____

Printed Name: _____ Title: _____

Address: _____ Phone: _____