**OUB Camper Health History**

OUB holds all health information privately. Information is shared only with the Camp Director and Camp Nurse except on a need-to-know basis to keep your child safe, healthy and secure.

Documentation required to accompany this health form:

 Copy of camper immunization record

 Copy of insurance card

 Copy of camper Covid-19 vaccination record

**Camper Information:**

Name:

Address:

Gender: Age: Birth Date: Transgender?

**Authorized Adult Care Giver:**

Name:

Address:

Phone 1: Phone 2:

Email:

**Alternate Emergency Contact:**

Name:

Address:

Phone 1: Phone 2:

Email:

**Physician Contact**

Family Physician’s Name:

Phone #:

Date of last physical exam by physician:

Activities restricted due to physical reasons or order by physician:

**Health Record:**

Please enter **c** for current, **p** for past history next to each condition, or leave blank if not applicable

**Conditions:**

 Ear infections Bed Wetting Frequent Colds

 Sleep Walking Sinusitis Hypertension

 Seizures/Epilepsy Urinary Tract Inf. Bronchitis

 Bleeding Disorder Fainting Heart Defect

 Constipation Diabetes Mononucleosis

 Photophobic Stomach Upsets Athletes Foot

 Other:

**Diseases:**

 Mumps Chicken Pox Ger. Measles

 Measles Infectious Dis. Whooping Cough

 Other:

**Allergies:**

 Asthma Hay Fever Poison Ivy

 Bee Stings Penicillin Sulfa

 Other:

Food Allergies:

If camper has an allergy, please state the allergen, the amount of allergen that can cause a reaction, and explain type of reaction.

Environmental Allergies:

If camper has an allergy, please state the allergen and type of reaction:

Does camper need to carry an EpiPen or asthma inhaler? YES NO

Does camper have any special health or behavioral considerations? If Yes, explain.

Operations or serious injuries (include dates):

Disabilities or chronic or recurring illnesses:

Has the camper been exposed to or have any current infectious diseases, such as Hepatitis A?

Dietary modification or special diet:

**Insurance:**

Do you carry medical/hospital insurance? YES NO

If so indicate Carrier:

Policy #: Group #:

**PLEASE SUPPLY A COPY OF CAMPER’S INSURANCE CARD WITH THIS FORM**

**Medication:**

List any prescription drugs or nonprescription drugs and medications camper takes currently:

Name Dosage Frequency

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**NO MEDICATION CAN BE DISPENSED UNLESS IN THE ORGINAL PHARMACY CONTAINER WITH THE PROPER DOCUMENTATION FOR DOSAGE AND THE NAME OF THE DRUG AND DOCTOR’S CONTACT INFORMATION IS VISIBLE. IF YOUR DOCTOR HAS CHANGED THE DOSAGE OR YOU DO NOT HAVE THE ORIGINAL CONTAINER, YOU MUST PROVIDE WRITTEN DOCUMENTATION FROM THE PHYSICIAN FOR US TO DISPENSE MEDICATION CONTRARY TO THE INSTRUCTIONS ON THE CONTAINER.**

**ALL PRESCRIPTIONS AND OVER-THE-COUNTER MEDICINE WILL BE KEPT AND DISPENSED BY THE CAMP NURSE.**

**Permission To Treat Minors For Routine Treatment & Over-The-Counter Medications**

I hereby give permission for the OUB Camp Medical Officer to provide non-surgical, routine medical care for,

Camper’s Name:

This includes:

* Routine health care
* Administer medications if necessary
* Order x-rays, routine tests, and treatments if necessary
* Release medical records necessary for insurance purposes
* Provide or arrange related transportation

Medications may include but are not limited to:

* Tylenol or similar preparation for headaches or earaches
* Pepto Bismol, Tums, Mylanta or generic preparation for upset stomach
* Immodium for diarrhea
* Ibuprofen for sprains, strains, inflammation, menstrual cramps
* Calamine lotion or similar preparation for poison ivy/rashes
* Benadryl for severe itching

Dosages will be administered according to directions on the container unless physician directs otherwise.

Parent/ Guardian Signature Date

If you have other information or concerns, please put them here:

If there is a religious objection to consenting to receipt of emergency medical or surgical treatment, the Authorized Adult Care Giver shall submit a written statement to the effect that the camper is in good health and that the person signing assumes the health responsibility for the camper.

**To Enter Camp:**

State law prohibits a director from admitting a camper without a record of 1 dose of each of the following vaccinations: Measles, Mumps, Rubella, Polio, DPT

 DPT - diphtheria, tetanus, pertussis (Whooping Cough)

 DT - Diphtheria, tetanus

 Td - Tetanus, diphtheria (adult)

Immunization Record (Please indicate most recent date for each):

DPT Measles

MUMPS Chicken Pox (Varicella)

HIB (haemophilus influenza b) TB test

Hepatitis B Tetanus

Due to the high rate of immunocompromised campers we service, we are **REQUIRING** proof of a negative Covid-19 test to participate in camp sessions. Campers who are fully vaccinated must provide the results of a rapid antigen test within 48 hours of check-in. Campers who are NOT fully vaccinated must provide the results of a PCR test within 48 hours of check-in.

If immunization is against your religious beliefs, you must sign the exemption form provided by the State of Michigan and present it to the Health Officer.

In the event your child becomes ill and is not well enough to function in scheduled programs, or may be contagious to other campers, it is the responsibility of the parent/guardian to come to the camp and transport the camper home.

**This Section Must be Completed for Attendance**

I submit that this information is true to the best of my knowledge and the camper herein described has permission to engage in all camp activities except as noted. I release and discharge Opportunities Unlimited for the Blind and its agents from any damages that may arise directly or indirectly from the camper’s participation in this camp.

Camper or Minor Release

In the event of an emergency and I cannot be reached, I give permission to the physician or hospital selected by the camp administration, to hospitalize, secure proper anesthesia, order injection, surgery, and do whatever else appears medically necessary.

Name of Camper (print):

Parent/ Guardian Signature Date