

MICHINDOH EMERGENCY MEDICAL AUTHORIZATION AND INFORMATION FORM

Please mark which week your child will be attending.

Week of Camp: _____

Camper's Name: First: _____ Last: _____ Date of Birth: _____ Sex: _____ M _____ F
 Address: _____ City: _____ State: _____ Zip: _____ Home Phone: _____
 Parent or Legal Guardian(s) Name(s): _____
 Work Phone Number (Dad): _____ Work Phone Number (Mom): _____
 Cell Phone Number (Dad): _____ Cell Phone Number (Mom): _____
 Emergency Contact (If Parent or Guardian cannot be reached) Name: _____ Relation to Camper: _____ Phone: _____
 Medical Insurance Company: _____ Policy number: _____

Michindoh maintains a supply of commonly used over-the-counter medications for first aid treatment. Please DO NOT send bottles of Tylenol, Advil, Cough drops, Band-Aids, etc. We highly recommend sending specific over-the-counter medications if your child can only have a specific brand due to allergies or medications.

Due to Federal and State Law ALL medications must be in their original packages, and be in the name of the camper taking the medication. i.e. prescriptions in the prescription bottle, Tylenol in the Tylenol bottle, herbs in the bottle that they were originally bought in. All prescription medications must have the prescription label. If you have an inhaler, the box with the label must come with it. ***We cannot give the prescription medication without the label.*** If the dose or times have changed from the label on the bottle, we must have a note with the changes on it and the doctor's signature.

Please list any medications that your child will be taking while at camp.

Name of Med	Dose	Reason for Med	When taken
example: Accolate	1 pill, 2 times a day	Asthma	Breakfast, Dinner
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If you need more room for the medications or health history, please provide on separate sheet of paper. Thanks!

Health History: (please check if applicable)
 Convulsions/Seizures Bedwetting Diabetes Migraines Date of last Tetanus Booster: _____
 Frequent ear infections Behavioral disorders Asthma Sleepwalking Please List Any Other Potential Health Problems
 Headaches-mild Emotional Disorders Bleeding/Clotting Disorders _____
 Please list any Current Infectious Diseases: _____

Immunization History:

Allergies: (please check if applicable)
 Bee stings Poison Ivy (severe reaction) Seasonal/Hay Fever Environmental Immunizations up to date according to your state requirements: Yes No
 Animal allergies (please list) Food allergies (please list) Medication allergies (please list)

REQUIRED FOR EACH YOUTH CAMPER: I HEREBY GIVE PERMISSION TO MICHINDOH, LICENSED BY THE STATE OF MICHIGAN FAMILY INDEPENDENCE AGENCY, TO SECURE EMERGENCY MEDICAL AND SURGICAL TREATMENT. ALSO TO PROVIDE ROUTINE, NON-SURGICAL MEDICAL CARE FOR THE MINOR CHILD NAMED ABOVE WHILE ATTENDING CAMP. I RELEASE ALL PHOTOS, VIDEO AND AUDIO TAPES OF MY CHILD TO MICHINDOH FOR PROMOTIONAL PURPOSES SUCH AS BROCHURES, VIDEO, WEB PAGES, ETC.

I certify that this information is true to the best of my knowledge.

 Parent or Legal Guardian Signature

 Date