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
____Frequent ear infections ____Behavioral disorders ____Asthma ____Sleepwalking
____Headaches-mild ____Emotional Disorders ____Bleeding/Clotting Disorders
Please list any Current Infectious Diseases: _____

Date of last Tetanus Booster: _____
Please List Any Other Potential Health Problems
_____
_____

Immunization History:

Allergies: (please check if applicable)
___Bee stings ___Poison Ivy (severe reaction) ___Seasonal/Hay Fever ___Environmental
___Animal allergies (please list) ___Food allergies (please list) ___Medication allergies (please list)
_____

Immunizations up to date according to your state requirements: ____ Yes ____No

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