

HEALTH RECORD

Blue Lake International Exchange Program

Dear Custodial Parent or Guardian:

Blue Lake International requests the following information so that the program and parent can work together to meet the physical and psychological needs of the student. All information is confidential. Please complete both sides of this form (use pen), attach copies of any prescriptions, including any medication or eyewear, and mail to: Blue Lake International Exchange Program, 300 East Crystal Lake Rd., Twin Lake, MI 49457. This Health Record and photocopy of health insurance card are due January 1.

M.I.

INTERNATIONAL GROUP: _____

STUDENT'S NAME _____ BIRTHDATE ____/____/____ GENDER ____
m/f

ADDRESS _____ TELEPHONE (____) _____

CITY _____ STATE _____ ZIP _____

CUSTODIAL PARENT or GUARDIAN NAME _____

ADDRESS _____

First Name:

CITY _____ STATE _____ ZIP _____ PARENT EMAIL _____

HOME TELEPHONE (____) _____ WORK TELEPHONE (____) _____ CELL PHONE (____) _____

EMERGENCY CONTACT #1 _____
(If parent or guardian is unreachable) _____ relationship _____

HOME TELEPHONE (____) _____ WORK TELEPHONE (____) _____ CELL PHONE (____) _____

EMERGENCY CONTACT #2 _____
(If parent or guardian is unreachable) _____ relationship _____

HOME TELEPHONE (____) _____ WORK TELEPHONE (____) _____ CELL PHONE (____) _____

Last Name:

Does your child have any of the following problems? If yes, please mark accordingly:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Hay fever | <input type="checkbox"/> Asthma | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Eczema or frequent skin rashes |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Seizures | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Speech problems | <input type="checkbox"/> Dental problems | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Mumps | <input type="checkbox"/> Whooping cough | <input type="checkbox"/> Chicken pox |
| <input type="checkbox"/> Rubella | <input type="checkbox"/> Scarlet fever | <input type="checkbox"/> Hives | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Menstrual irregularities | | | |
| <input type="checkbox"/> Frequent sore throats, ear aches, colds | | | |
| <input type="checkbox"/> Trouble passing urine or bowel movements | | | |
| <input type="checkbox"/> Other current infectious diseases: _____ | | | |
| <input type="checkbox"/> Other _____ | | | |

If other, please explain and note any additional chronic medical problems: _____

yes no Has your female child been told about menstruation? yes no Has she had her first menstruation?

yes no Has your child had any major surgery or injuries? If yes, please describe, list approx. date of injury and procedure: _____

International Group:

MEDICATIONS: * Prescriptions must not expire during tour! Medications (prescription & non-prescription) must be labeled with student name and be in original container. If necessary, attach additional information on separate paper.

Medication _____ Strength _____ Dosage _____ Frequency _____

Medication _____ Strength _____ Dosage _____ Frequency _____

Medication _____ Strength _____ Dosage _____ Frequency _____

Medication _____ Strength _____ Dosage _____ Frequency _____

yes* no Does your child have any allergies to food, medication, or other? If yes, please list allergy, type of exposure, and reaction (ex: allergic to peanuts. If eats them, will have difficulty breathing): _____

yes* no Should your child's activity be restricted because of any physical defect, illness, or concern? If yes, please explain degree of restriction: _____

yes* no Does your child have any concerns requiring special attention or care? Please list any physical, medical, psychological, cognitive, or other condition requiring special attention or care (such as diabetes, seizure disorder, cardiac conditions, significant dietary restrictions, fainting, sleepwalking, fear of storms, bed wetting, etc.): _____

yes* no Has your child ever consulted or been referred to a psychiatrist, psychologist, or mental health therapist for professional assistance? If yes, please explain: _____

***NOTE:** If the answer is "yes" to any of the previous 4 questions, please be sure to provide any relevant information that will assist our staff leadership in providing a positive camp experience for your student. If desired, attach a letter or comments to this Health Record. Information from an attending physician (or psychiatric or psychological counselor) is welcome, but not required. All information is confidential.

yes no Do you feel that your child is prepared mentally and has reached a maturity level necessary for adapting to a social environment such as an overnight camp?

yes no Did your student attend Blue Lake Fine Arts Camp previously? If so, please list year(s): _____

IMMUNIZATIONS:

Please enter the date of your child's last tetanus shot: ____/____/____ Tetanus

yes no Are your child's immunizations (measles, mumps, rubella, hepatitis B, diphtheria, whooping cough, polio) up to date?

yes no Has your child had chicken pox before?

HEALTH INSURANCE: Does your child have health insurance? yes no If yes, please complete the information below.

POLICY HOLDER _____ POLICY HOLDER BIRTHDATE ____/____/____

PLACE OF EMPLOYMENT _____

NAME OF HOSPITALIZATION INSURANCE CO. _____

POLICY NUMBER _____ CAMPER SOCIAL SECURITY#: _____ - _____ - _____

Staple a photocopy of any health insurance cards to this Health Record. Please write your student's name and group on the copy, in the event that the it gets detached from the health form!!!

AUTHORIZATION:

Is there anything in your religious beliefs that should be given consideration in the treatment of your child's health or in case of an emergency? yes no

If yes, please explain: _____

I hereby consent to any and all diagnostic procedures, examinations, care, and treatment as deemed necessary by the Camp Health Officer or designated licensed physician. I further consent to authorize the camp's designated physician to refer my child for consultation to any licensed medical specialist as judged necessary, and give authority to any such physician or surgeon to render any diagnostic procedures, examinations, care, or treatment that he/she may deem necessary or advisable.

In case of a serious accident or illness involving your child while he/she is in the custody of the camp, every effort will be made to contact a parent or guardian. Because I understand that a situation could arise when emergency treatment may be necessary and I can not be reached, I hereby authorize camp personnel to make provisions for treatment with the appropriate medical personnel or facility.

Further, I understand and agree that the camp and its medical staff will not accept responsibility for the following A) Medication not prescribed by the camp's designated physician and action resulting from its use, and B) actions of the student that are contrary to medical advice.

_____/_____/_____
custodial parent or legal guardian signature (please use pen) _____/_____/_____
date