

HEALTH HISTORY RECORD

Michigan Department of Licensing and Regulatory Affairs

Dear Authorized Person:

The following information is requested so that the camp can better meet the physical, intellectual, and emotional needs of the camper or minor staff. Fill out the information requested. (Use back of form if additional space is required.) "Authorized person" means a parent, guardian, or adult camper's designee.

Minor Child's Name (Last)		First		Middle	Sex	Date of Birth	
Address (Number and Street)			City		Zip		Telephone (Home)
Authorized Person's Name (Last)		First		Middle		Telephone (Work)	
Address (Number and Street)			City		Zip		Telephone (Emergency)
Is the minor child having any of the problems listed below?				Yes	No		
1.	Hay fever, asthma, or wheezing			<input type="checkbox"/>	<input type="checkbox"/>	7.	Trouble with passing urine or bowel movements
2.	Eczema or frequent skin rashes			<input type="checkbox"/>	<input type="checkbox"/>	8.	Shortness of breath
3.	Convulsions/seizures			<input type="checkbox"/>	<input type="checkbox"/>	9.	Speech problems
4.	Heart Trouble			<input type="checkbox"/>	<input type="checkbox"/>	10.	Menstrual Problems
5.	Diabetes			<input type="checkbox"/>	<input type="checkbox"/>	11.	Dental problems
6.	Frequent colds, sore, throats, ear aches (4 or more per Year)			<input type="checkbox"/>	<input type="checkbox"/>	12.	Other
Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>							
Please explain any problem areas identified above including any current infectious diseases:							
If female has she been told about menstruation (answer if appropriate)				Has she menstruated (answer if appropriate)			
<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No			
Operations or Injuries							
Explain Any Special Health, Behavioral or Emotional Consideration(s)							
Medication Needed or Used (Including Psychiatric)						Currently Being Given	
Name	Frequency			Dosage		<input type="checkbox"/> Yes	<input type="checkbox"/> No
						<input type="checkbox"/> Yes	<input type="checkbox"/> No
						<input type="checkbox"/> Yes	<input type="checkbox"/> No
Special conditions to be watched for such as ALLERGY (Reactions to food, Penicillin, or other drugs), Bedwetting, Fainting, Sleep Walking, etc.							
Immunizations: Are the minor child (age 5 and older) immunizations up to date? <input type="checkbox"/> Yes <input type="checkbox"/> No							
For children under age five attending camp attach a certificate of immunization record and status of the minor child's immunizations or provide a written religious or other exemption waiver signed by a physician.							
Should the camper's activity be restricted because of any physical limitation or illness? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, explain degree of restriction:							
<input type="checkbox"/> Medical Emergency Care Authorization: I hereby give permission to the children's camp to secure emergency medical and surgical treatment and to provide routine, nonsurgical medical care, for the minor child named above, while attending camp. By signing below, I authorize care.				<input type="checkbox"/> For Religious Exemption: I object to consent to receipt of emergency medical or surgical treatment, by signing below I attest that my child is in good health, and I assume the health responsibility for my child.			
I certify that this information is true to the best of my knowledge.		Authorized Person's Signature					Date
LARA is an equal opportunity employer/program.				Authority: PA 368 of 1978, PA 116 of 1973			