2018 Mail to:
P.O. Box 1129
Frankfort MI, 49635

Name: _____

Trip/Session: _____ Dates: ___/___/___ to ___/___/___

Gender: _____ Birth date: _____ Age when trip/session begins: _____

Please follow the instructions carefully and complete the form as thoroughly as possible. This form should be submitted two-weeks before your trip or session begins.

CONTACT INFORMATION

Primary Parent/Guardian Contact (with legal custody)

Name:_____ Relationship to Participant:_____ Home Phone: (___)_____ Cell Phone: (___)_____

Street Address:_____ City:_____ State:_____ Zip Code: _____

Secondary Parent/Guardian Contact

Name:_____ Relationship to Participant:_____ Home Phone: (___)_____ Cell Phone: (___)_____

Street Address:_____ City:_____ State:_____ Zip Code: _____

Additional Emergency Contact if parent/guardian cannot be reached

Name: _____ Relationship to Participant:_____ Preferred Phone(s): (____)_____ E-mail:_____

Primary Care Physician

Name: _____ Preferred Phone(s): (_____)_____ E-mail:_____

Office Address: _____

Allergies: ☐ No known allergies. Allergic to: ☐ Food ☐ Medicine ☐ Environmental Agents ☐ Other: _____

Please describe below what the participant is allergic to and the reaction seen:

Diet, Nutrition: ☐ No Dietary Restrictions ☐ Vegetarian Diet ☐ Vegan Diet ☐ Gluten Free ☐ Special food needs (describe below):

Additional Restrictions: Please describe any additional restrictions (i.e. on activities, diet, medical treatment, etc…) you wish us to be aware of.

MEDICAL INSURANCE

This participant is covered by family medical/hospital insurance ☐ *Yes* ☐ *No*

Insurance Company: _____ Policy Number: _____

Subscriber: _____ Subscriber Date of Birth: ___/___/___ Insurance Company Phone:(___)_____

Please include a copy of your insurance card; copy both sides of the card so information is readable.

Please include a copy of your child's immunization history. By submitting this signed form you acknowledge that you understand and accept all risks to your child from not being fully immunized.

Participant Health History 2018

Participant Name: _____ Birth date: __/__/__

MEDICATION

Medication: ☐ This participant will not take any daily medication(s) while participating.
☐ This participant will take the following daily medication(s) while participating.

Medication must be provided in its original container!

Medication	*Date first taken*	*Reason for medication*	*Time medication can be given*	*Dose given*	*How is the medication given?*
	/ /				
	/ /				
	/ /				
	/ /				

Please indicate any medications you do not want us to use:

ADDITIONAL INFORMATION

HAS THE PARTICIPANT:

	Yes	No		Yes	No
Ever been hospitalized?	☐	☐	Had fainting or dizziness?	☐	☐
Ever had surgery?	☐	☐	Passed out/had chest pain during exercise?	☐	☐
Have recurrent/chronic illnesses?	☐	☐	Had mononucleosis ("mono") during the past 12 months?	☐	☐
Had a recent infectious disease?	☐	☐	If female, have problems with periods/menstruation?	☐	☐
Had a recent injury?	☐	☐	Have problems with falling asleep/sleepwalking?	☐	☐
Had asthma/wheezing/shortness of breath?	☐	☐	Ever had back/joint problems?	☐	☐
Have diabetes?	☐	☐	Have a history of bedwetting?	☐	☐
Had seizures?	☐	☐	Have problems with diarrhea/constipation?	☐	☐
Had headaches?	☐	☐	Have any skin problems?		
Wear glasses, contacts, or protective eyewear?			Traveled outside the country in the past 9 months?	☐	☐

Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?	☐	☐
Ever been treated for emotional or behavioral difficulties or an eating disorder?	☐	☐
During the past 12 months, seen a professional to address mental/emotional health concerns?	☐	☐
Had a significant life event that continues to affect the participant's life?	☐	☐

(i.e. history of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

If you selected yes, please attach any pertinent information on a separate page.

FOR PHYSICIAN

This portion to be completed by a physician.

Date of last physical: __ / __ / __ ***(Per ACA guidelines, we require a physical within the last 24 months.)***

Weight: lbs Height: ___ft in

Please ensure all pertinent information is included in, or attached to this document.

I have reviewed this form and have discussed the camp program with the participant's parent(s)/guardian(s). It is my opinion that the participant is physically and emotionally fit to participate in an active camp program (except as noted above in "additional restrictions".)

Primary Physician Signature _____ Date: _____

AFFIRMATION

This health history is correct and accurately reflects the health status of the participant to whom it pertains. The person described has permission to participate in all provided activities except as noted by me and/or an examining physician. I give permission to the physician selected by Crystalaire, Inc (Camp Lookout) to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with Crystalaire, Inc (Camp Lookout) staff. I give permission to photocopy this form. In addition, Crystalaire, Inc (Camp Lookout) has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Parent/Guardian Signature:_____ Date:_____ Relationship to Participant: _____