SCHOOL NAME: _____ **Dates Attending:** _____

EMERGENCY MEDICAL AUTHORIZATION AND INFORMATION

Students Name: Last: _____ First: _____
Address: _____ City: _____ State: _____ Zip:_____
Date of Birth: _____ Sex: _____ M _____F Home Phone: _____
Parent or Legal Guardian(s): Name(s) _____
Work Phone # (Dad): _____ Work Phone # (Mom): _____
Cell Phone # (Dad): _____ Cell Phone # (Mom): _____
Emergency Contact (If Parent or Guardian cannot be reached):
Name : _____ Relation to Student: _____ 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 that your child takes regularly such as vitamins.

Due to Federal & State Law ALL medications must be in their original packages and be in the name of the student taking the medication. i.e. presriptions in the prescription bottle, Tylenol in the Tylenol bottle, herbs in the bottle they were bought in. All prescription medication must have the prescription label. If you have an inhaler, the box must come with it. ***We CAN NOT 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.

ALL MEDICINE MUST BE IN THEIR ORIGINAL CONTAINERS.

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 2X a day	Asthma	Breakfast, Dinner

If you need more room for the medications or health history, please use the back side. Thanks!

Health History: (please check if applicable)

_____ Convulsions/Seizures
_____ Frequent ear infections
_____ Heart trouble
_____ Headaches-mild
_____ Bedwetting
_____ Behavioral disorders
_____ Bleeding/Clotting disorders
_____ Diabetes
_____ Asthma
_____ Wheezing
_____ Migraines
_____ Sleepwalking
_____ Emotional disorders

Allergies:

_____Bee Stings - treated with _____
_____ Poison Ivy (severe reaction)
_____ Seasonal /Hay fever
_____ Environmental
_____ Animal(please list)_____
_____ Food (please list)_____

Other potential health problems or restricted activities: _____
_____
_____

Medication Allergies (please list)
_____
_____

Please list any other potential health problems: _____
_____

Immunization History:
Immunizations up to date according to your state requirements: _____ YES _____ NO
Date of last Tetanus Booster: _____

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