

Camp Au Sable

2590 Camp Au Sable Drive Grayling, MI 49738 989.348.5491

Camper Medical Information

PLEASE DO NOT MAIL OR FAX BACK

To ensure confidentiality and up-to-date information, please fill out just prior to start of camp and give to camp nurse at registration.

Camper's Name: _____		Cabin/Counselor: _____/_____	
<i>Last</i>	<i>First</i>	<i>(office use only)</i>	
Date of Birth: _____	Age: _____	Male: _____	Female: _____
<i>Mo/Day/Yr</i>			
Please check week(s) attending: Adventure _____ Wilderness Survival _____ Junior _____ Tween _____ Teen _____			
Specialty _____ Family I _____ Family II _____ Family III _____ Mini-Family _____			
Parent/Legal Guardian: _____		Emergency Contact: _____	
Address: _____			
<i>Street or PO Box</i>		<i>City</i>	<i>State</i>
<i>Zip Code</i>			
Emergency Phone Numbers: Day: () _____		Evening: () _____	
Cell: () _____			
Insurance Information Attached: Yes _____ No _____ If no, please explain: _____			
<i>Important Note: Must have a photocopy of health insurance card (front and back) in order to treat camper in an emergency!</i>			
Physician/Health Care Facility: _____			
Phone Number: () _____		Date of last physical exam: _____	
Are all school physicals/immunizations up to date: Yes _____ No _____ If not, please explain: _____			
Date of last tetanus (DPT/TD) _____		If needed, may tetanus booster be given? Yes _____ No _____	
<i>Mo/Yr</i>			

Allergies:	No Allergies	Medication Allergies	Food Allergies	Other Allergies
	_____	_____	_____	_____
		_____	_____	_____
		_____	_____	_____

Routine Medication: _____

Prefer private medication administration

Camper's Health History - Please Check

	Yes	No		Yes	No
1. Upset stomach?	_____	_____	7. Recent injury, infection, infectious disease?	_____	_____
2. Frequent ear infections?	_____	_____	8. Chronic or recurring illness/conditions?	_____	_____
3. Frequent headaches?	_____	_____	9. Any physical restrictions?	_____	_____
4. Ever had seizures?	_____	_____	10. If female, menstrual difficulties?	_____	_____
5. Diabetes?	_____	_____	11. Any other health conditions requiring treatment?	_____	_____
6. Asthma?	_____	_____	12. Any past medical treatment/operations?	_____	_____

If "yes" please explain: _____

◇ There will be a head lice check at registration. Each camper must be lice-free before they can be checked into a cabin. (To be initialed by medical staff at registration: no lice _____ recheck _____ yes _____)

I hereby give Camp Au Sable permission to provide routine health care (which includes over-the-counter drugs, first-aid for cuts, sprains, bruises, etc.), administer prescription medications, and seek emergency treatment as needed. In case of emergency, I hereby give permission to the camp physicians selected by the camp directors to secure proper treatment including: routine tests, x-rays, treatment, hospitalization, anesthesia, surgery, and to release any records necessary, as well as to provide or arrange necessary related transportation. I certify that the above information is correct and current to the best of my knowledge.

_____ Signature of Parent/Guardian	_____ Date	_____ Camp Nurse	_____ Date
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