

Please return the entire booklet. Thank You!

First Name _____ Last Name _____



S.T.A.R.S.

Hurley Community
Education

Iron County Summer Youth Camp

Camper and Staff Information

&

Health Records 2008



**Health and Release Statement
For Members Attending Iron County Camp.**

The Iron County Summer Youth Camp is held to provide enjoyable and educational camping experiences for Iron County youth. To insure a successful event, the health, welfare and participation of the campers must receive consideration.

YOUTH WHO HAVE A SORE THROAT, HEAD OR CHEST COLD, OR OTHER SIMILIAR ILLNESSES SHOULD NOT ATTEND THIS FUNCTION. A YOUTH UNDER DOCTOR'S CARE SHOULD PROVIDE THE NECESSARY INFORMATION FOR PROTECTION OF HEALTH BY COMPLETING THE FOLLOWING ITEMS. A PARENT OR GUARDIAN **MUST** COMPLETE AND SIGN THE STATEMENT REGARDING THE HEALTH OF THEIR SON OR DAUGHTER PARTICIPATING IN IRON COUNTY CAMP.

NOTE: THIS FORM MUST BE COMPLETED AND TURNED IN FOR ALL CAMPERS AND STAFF, THIS IS VERY IMPORTANT INFORMATION!!

Data Form Completed: _____
(Date)

Campers Name: _____ Sex: M _____ F _____

Age: (as of Jan. 1) ____ Birthdate: ____/____/____ Phone No. () _____

Parent's or Guardian's Names: _____

Parent's Place (s) of work and phone _____

Second Parent or Guardian or Emergency Contact _____

Home Address _____ Phone _____

Business Address _____ Phone _____

If not available in an emergency, notify

Name _____ Relationship _____

Address _____ Phone _____

Family Physician: _____ Phone _____

Family Dentist: _____ Phone _____

Orthodontist: _____ Phone _____

Family Health Insurance Co. _____

Health Insurance No. _____ Group # _____

Is this individual subject to or bothered frequently with any of the following?
 Check all that apply.

	Have Had	Have Now		Have Had	Have Now
Colds or Flu			Hernia		
Ear Infection			Heart Trouble		
Sinusitis			Rheumatic Fever		
Tonaillitis			Asthma or Hay Fever		
Sore Throat			Constipation		
Diarrhea			Drug Sensitivity		
Menstrual Cramps			Headaches		
Hearing Problems			Athletes Foot		
Upset Stomach			Fainting Spells		
Epilepsy			Bladder/Kidney Problems		
Rashing			Ivy Poisoning, etc.		
Asthma			Insect Stings		
Hay Fever			Penicillin		
Other			Other Drugs		

Please attach special instructions for the nurse and or staff.

The individual was last examined by a physician: Month _____ Year _____

Vaccinations are up to date? Yes ___ No___

DPT? Yes ___ No___

Tetanus? Yes ___ No___

Oral Polio Vaccine? Yes ___ No___

Measles/Mumps/Rubella/MMR? Yes ___ No___

Exposed to communicable diseases within the past two weeks? Yes ___ No___

Which one if yes?

Has this individual stayed away overnight from the family before? Yes___ No___

Eye Glasses/Contacts: Yes___ No___ (Please mark with child's name)

Hearing Aid Yes ___ No ___

Is this individual subject to any of the following?

This individual has been previously known to:

Tire Easily	Yes	No	Fear of Darkness	Yes	No
Bed Wetting	Yes	No	Homesickness	Yes	No
Nightmares & Scary Dreams	Yes	No	Sleep Walking	Yes	No
Fear of Water	Yes	No	Has had swimming lessons	Yes	No
Can child swim	Yes	No	Other		

Limit physical exercise	Yes___	No___
Use a special diet	Yes___	No___
Take a special medication	Yes___	No___
Other Specific instructions	Yes___	No___

If the answer to any of these is "Yes," please explain: _____

This health history is correct as far as I know and my son/daughter/ward has permission to engage in all prescribed activities, except as noted by me and the physician. In the event of a serious injury or illness, I will be notified. If I cannot be reached in an emergency, I hereby give permission to the physician to hospitalize, secure proper treatment for and/or to order injection, anesthesia or surgery for my son/daughter/ward. I also give my permission for my son/daughter/ward to be transported to a hospital by ambulance or other appropriate transportation if needed. I also agree not to hold North Lakeland Discover Center or the U.W. Extension, or the Hurley School District liable for any personal injury or accident while at camp.

I hereby grant permission to the Iron County Summer Youth Camp Staff to give the medication(s) to my child, according to the directions stated above and further authorize them to contact the child's physician. I agree to hold the Iron County Camp Staff who are acting within the scope of their duties harmless in any and all claims arising from the administration of their medication at camp.

I agree to notify the camp in writing at the termination of this request or when any changes in the above order is necessary.

Signature of Parent or Guardian

Date

If PARENTS ARE NOT AVAILABLE IN CASE OF EMERGENCY, NOTIFY:

Name: _____

Address: _____ Phone: _____

Iron County Camp

TODAY'S DATE: _____

ATTENTION PARENTS: Please arrange for a supply of your child's medication to be available at check in. Please **do not** send medications to camp with your child.

PERMISSION TO ADMINISTER MEDICATION

Request by parent for camp nurse to administer medication during the week of camp.

_____ request and authorize camp nurse to administer medication to
(Parent's name)
our son/daughter _____.
(Student's Name)

The medication is recommended and prescribed by _____.
(Doctor)

The following information is required regarding the prescription:

NAME OF PHARMACY _____ TELEPHONE NO. _____

ADDRESS _____

STUDENT'S NAME _____

NAME OF DRUG _____

DOSAGE TO BE GIVEN _____ ROUTE _____
(How Administered)

TIME(s) OF DAY (OR INDICATIONS) _____
(The above information should also be on the label of the medication)

ADDITIONAL COMMENTS AS MAY BE RELATED TO THIS MEDICATION:

(KNOWN ALLERGIES) _____

LIST ALL OTHER MEDICATIONS BEING TAKEN: _____

(Names of those authorized to give medication)

(Parent's Signature)

(Physician's Signature)

A separate permission form must accompany **EACH** prescription.
A photocopy of the prescription with the physician's signature may be submitted if physician's signature cannot be obtained.

