HEALTH RECORD
Blue Lake Fine Arts Camp

2018

To Custodial Parent or Guardian:

The following information is requested in advance so that the camp and parent can work together to meet the medical and psychological needs of your camper. All information is required and kept confidential. The Health Record and photocopy of health insurance card are due 30 days prior to your student's arrival at camp. Failure to provide this information in a timely manner will make it difficult for the health staff to adequately process your student's important health information. Please adhere to our deadline. This form may be mailed to Health Services, 300 E. Crystal Lake Rd, Twin Lake, MI 49457, or scanned and submitted electronically as a PDF via We Transfer www.wetransfer.com to healthservices@bluelake.org.

Please Print Clearly and use Pen.

SESSION(S): 4 UNIT: Villanelle CABIN: Moore MAJOR: Orchestra - Violin

☐ Yes ■ No Has your student attended Blue Lake Fine Arts Camp previously? If so, please list year(s) and session(s): _____

STUDENT'S NAME Jessica Mathew BIRTHDATE 01 / 15 / 2005 GENDER ☒ Female ☐ Male

PARENT / GUARDIAN 1 Roy Mathew CELL PHONE (248) 805-1864

ADDRESS 1704 Blushing Ct HOME PHONE (248) 275-1844

CITY Rochester Hills STATE MI ZIP 48307

WORK PHONE (_____) _____ EMAIL roymk@yahoo.com

PARENT / GUARDIAN 2 Anila Mathew CELL PHONE (248) 464-0985

ADDRESS 1704 Blushing Ct HOME PHONE (248) 275-1844

CITY Rochester Hills STATE MI ZIP 48307

WORK PHONE (_____) _____ EMAIL anilasusan@yahoo.com

Who is your child's legal custodial parent / guardian? ☒ Both Parents ☐ Parent / Guardian 1 ☐ Parent / Guardian 2

With whom does your child reside? ☒ Both Parents ☐ Parent / Guardian 1 ☐ Parent / Guardian 2 ☐ Other: _____

EMERGENCY CONTACT 1 Roopali Kamat (If parent or guardian is unreachable) Friend Relationship

CELL PHONE (248) 659-2528 WORK PHONE (_____) _____ HOME PHONE (_____) _____

EMERGENCY CONTACT 2 Symala Rejani (If parent or guardian is unreachable) Friend Relationship

CELL PHONE (248) 252-8752 WORK PHONE (_____) _____ HOME PHONE (_____) _____

AUTHORIZATION:

I hereby consent to any and all diagnostic procedures, examinations, care, treatment, and transportation as deemed necessary by the camp health officer or designated licensed physician. I further consent to authorize the camp's designated physician to refer my child for consultation to any licensed medical specialist as deemed necessary, and give authority to any such physician or surgeon to render any diagnostic procedures, examinations, care, or treatment that he/she may deem necessary or advisable. I also agree to the release of any records necessary for treatment, referral, billing or insurance purposes. Further, I understand and agree that the camp and its medical staff will not accept responsibility for the following A) Medication not prescribed by the camp's designated physician and action resulting from its use, and B) actions of the student that are contrary to medical advice.

It is my intention that representatives of the camp be considered 'personal representatives' for the purpose of disclosing health information that is protected under the Health Insurance Portability and Accountability Act of 1996. I also agree to the disclosure to camp representatives of protected health information of the person named herein in order to provide information related to the person's ability to participate in camp activities; and to provide information to the camp representatives to keep me informed of my child's health situation.

In case of a serious accident or illness involving your child while he/she is in the custody of the camp, every effort will be made to contact a parent or guardian. Because I understand that a situation could arise when emergency treatment may be necessary and I cannot be reached, I hereby authorize camp personnel to make provisions for treatment with the appropriate medical personnel or facility.

If circumstances require that my child leaves camp early due to illness, medical emergency, camp-wide emergency, expulsion, or other reason as deemed necessary by the camp administration, he/she must be released to a custodial parent, legal guardian, or family designate. Blue Lake will not release campers from the premises without a custodial guardian's written permission. Please indicate the person(s) that you trust to make decisions and/or transport and house your camper in the event that a parent or guardian is unreachable and/or unavailable:

☒ Emergency Contact 1 ☐ Emergency Contact 2 ☐ Other Emergency Designate: _____

Relationship to camper family: Family Friend Email: rejanis@gmail.com

Cell Phone: (248) 252-8752 Home Phone: (_____) _____ Work Phone: (_____) _____

_____ 08 / 02 / 2018

Custodial Parent or Legal Guardian Signature (please use pen) **date**

Session: 4 Unit: Villanelle Last Name: _____ First Name: Jessica Mathew M.I. _____

HEALTH HISTORY:

Does your child have any of the following concerns? If yes, please mark accordingly:

☐ Hay fever	☐ Shortness of breath	☐ Eczema or frequent skin rashes	☐ Hives
☐ Asthma	☐ Frequent sore throats, ear aches, colds	☐ Dental problems	☐ Menstrual irregularities
☐ Speech problems	☐ Heart Disease	☐ Trouble passing bowel movements	☐ Trouble passing urine
☐ Mononucleosis	☐ Hepatitis	☐ Ulcers	☐ Hernia
☐ Appendicitis	☐ Measles	☐ Mumps	☐ Tuberculosis
☐ Rubella	☐ Whooping cough (Pertussis)	☐ Rheumatic fever	☐ Scarlet fever
☐ Chicken pox			

☐ Diabetes, controlled by (please mark one): ○ Oral Medication ○ Daily Injections ○ an Insulin Pump

☐ Seizures or convulsions, please list type: _____

☐ Other current infectious diseases: _____

☒ Yes ☐ No ☐ n/a Has your female child been told about menstruation? ☒ Yes ☐ No Has she had her first menstruation?

☐ Yes ☒ No Has your child had any major surgery or injuries? If yes, please describe, list approximate date of injury/surgery or procedure:

_____

_____

☒ Yes ☐ No Do you feel that your child is prepared mentally and has reached a maturity level necessary for adapting to a social environment such as an overnight camp?

NOTE: If the answer is "**Yes**" to any of the following 3 questions, please provide detailed relevant information that will assist our staff leadership in providing a quality camp experience for your student. Attach comments or instructions to this Health Record, if necessary. Information from an attending physician (or psychiatric or psychological counselor) is welcome, but not required. All information is confidential.

☐ Yes* ☒ No Does your child have any allergies to food, medication, or other? If yes, please list allergy, type of exposure, and reaction:

Allergen (e.g. peanuts – ingestion only):	**Reaction** (e.g. swelling, difficulty breathing):	**Treatment** (e.g. Benadryl, EpiPen):

☐ Yes* ☒ No Should your child's activity be restricted because of any physical defect, illness, or concern? If yes, please explain degree of restriction:

_____

_____

☐ Yes* ☐ No Does your child have any concerns requiring special attention or care? Please list any physical, medical, psychological, social/emotional, cognitive, or other condition requiring special attention or care (such as diabetes, severe asthma, seizure disorder, cardiac conditions, autism spectrum disorder, behavioral concerns, significant dietary restrictions, fainting, sleepwalking, fear of storms, bed wetting, etc.):

_____

_____

_____

Is there anything in your religious beliefs that should be given consideration in the treatment of your child's health or in case of an emergency? ☐ Yes ☒ No

If yes, please explain: _____

IMMUNIZATIONS:

Please enter the date of your child's last tetanus shot: ___/___/___ Tetanus

☒ Yes ☐ No Are your child's immunizations (measles, mumps, rubella, hepatitis B, diphtheria, whooping cough, polio, varicella) up to date?

☐ Yes ☒ No Has your child had chickenpox before?

HEALTH INSURANCE:

Does your camper have health insurance? ☒ Yes ☐ No If yes, please complete the information below.

POLICY HOLDER Blue Cross Blue Shield POLICY HOLDER BIRTHDATE 05 / 26 / 1969

PLACE OF EMPLOYMENT Flagstar Bank, Troy Michigan POLICY NUMBER 007008259

NAME OF HOSPITALIZATION INSURANCE CO. _____

Staple a photocopy of any health insurance cards to this Health Record. Please write your camper's name, session, and housing unit on the copy, in the event that it gets detached from the health form!!!

Staple Here...

1. *Photocopy of health insurance card*
2. *Any additional information, if necessary*

MEDICATION CHECK-IN: Basic Information for Parents

State camp regulations require that all prescription and nonprescription medications be kept in secure, locked storage. Therefore, all medications (with the exception of emergency rescue medication such as Epi-Pens, diabetic supplies, asthma inhalers) will be kept in Blue Lake's locked medical facilities or in locked unit first-aid stations (see Medication Storage Locations, below). The state also requires that all medications be in the original container.

Upon arrival at camp, all medications and medical supplies (e.g. Band-aids) must be checked in at the Unit Director's Hut in the camper's housing unit. Following this check-in, all camper medications will be reviewed by the Camp Nurse and other Health Officers. **Please make sure that medications are in original containers, will not expire during the camp session, and that there is enough medication to last the entire session.** The Unit Director will review the medication information with you, label the medication as needed, and confirm the information on your camper's health form.

Please do not send over-the-counter medications to camp with your child to be taken as needed (e.g. Tylenol, Advil, Band-Aids, Neosporin, Caladryl, etc.). Commonly used medications are readily available in the Health Lodge if needed.

MEDICATION STORAGE LOCATIONS

MEDICATIONS STORED WITH THE CAMPER:

Rescue medications and supplies may be carried with campers as needed. Such medications include Epi-Pens, rescue asthma inhalers, Glucose tablets and other diabetic supplies, etc. Any rescue medications stored with the camper must be listed on the Health Form and labeled during the medication check-in process.

MEDICATIONS STORED BY THE CAMP:

1. HEALTH LODGE: The health staff will track all medications stored in the Health Lodge and administer medications as designated at check-in. If a camper misses a dose, the health staff will follow up with the camper to administer the medication.

- All oral and injectable prescription medication.
- Topical medications (cream, ointment, etc.) prescribed for a wound or other injury.
- Any refrigerated medications.
- Any supplies related to prescription medications (e.g. diabetic supplies, syringes, lancets, nebulizers, spacers, etc.)
- Daily over-the counter medications (e.g. Claritin, Prilosec, vitamins, etc.)

2. HOUSING UNIT: The unit staff will log and administer these medications as needed; they will not be tracked by the health staff.

- Topical medications prescribed for basic daily use (e.g. dermatological prescriptions).
- As-needed over-the-counter medications or supplies (not daily medications).

Please help us expedite your check-in by completing the following information. <u>Do not complete shaded section or sign below</u> until you have reviewed this information completely with a Blue Lake health representative. Your child's Unit Director will be available on opening day to check in medications and review dosing instructions.

Camper Name: Jessica Mathew Unit: Villanelle Cabin: Moore

					<u>Do Not</u> complete this section. You will review medications with your child's Unit Director on Opening Day.
☐ Prescription ☐ Over-the-counter	**Medication or Item:**	**Strength:**	(such as mg or mcg)		Location: ☐ Health Lodge ☐ Unit ☐ Camper (rescue)
	Dosage: (i.e. 1 tablet or 2 puffs)	**Frequency:**	(such as: Breakfast, Lunch, Dinner, AM,PM, Night)		
☐ Prescription ☐ Over-the-counter	**Medication or Item:**	**Strength:**	(such as mg or mcg)		Location: ☐ Health Lodge ☐ Unit ☐ Camper (rescue)
	Dosage: (i.e. 1 tablet or 2 puffs)	**Frequency:**	(such as: Breakfast, Lunch, Dinner, AM,PM, Night)		
☐ Prescription ☐ Over-the-counter	**Medication or Item:**	**Strength:**	(such as mg or mcg)		Location: ☐ Health Lodge ☐ Unit ☐ Camper (rescue)
	Dosage: (i.e. 1 tablet or 2 puffs)	**Frequency:**	(such as: Breakfast, Lunch, Dinner, AM,PM, Night)		
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	Dosage: (i.e. 1 tablet or 2 puffs)	**Frequency:**	(such as: Breakfast, Lunch, Dinner, AM,PM, Night)		

DO NOT SIGN UNTIL YOU HAVE REVIEWED ALL MEDICATIONS WITH BLUE LAKE STAFF ON OPENING DAY! :

I have consulted with the Blue Lake staff and agree that the above listed medications are categorized appropriately for my child's needs.

_______________________________ ___/___/___

Custodial parent or guardian signature date

_______________________________ ___/___/___

Blue Lake Staff signature (Unit Director or Health Staff) date