2017 LEAP Summer Program Participant Medical Form

Please print. Please complete a separate form for each student being sent from your household.

Participant Name____

Insurance Policy & Group #____

Doctor's Name____Phone_________________________

(You MUST provide copy of the participant's MEDICAL INSURANCE COVERAGE to attend camp)

Medical History:

Allergies (i.e. medicine, foods, molds, pollens bees, etc.)____

____

Major Illnesses & Past Surgeries____

____

Infectious Diseases____

____

Disabilities/Limitations____

____

Check all of the following illnesses & complications that apply.

☐ Respiratory Problems
☐ Heart or Circulation
☐ Pulmonary Edema
☐ Hay Fever
☐ Balance Problems
☐ Insect Bites
☐ Food Allergy
☐ Hypoglycemia
☐ Dizzy Spells
☐ Anaphylactic Shock
☐ Diabetes
☐ Drug Allergy
☐ Hypertension
☐ Foot Problem
☐ Seizure Disorders
☐ Poison Oak
☐ Fainting
☐ Other

Details____

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Please explain any physical limitations that would prevent student's full participation in camp and list any restricted activities.

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Immunization History: Please fill in dates of basic immunizations and most recent booster as best you can.

Tetanus Booster_______________ Hep B_______________ MMR (Measles, Mumps, Rubella)_______________

Polio OPV (Sabin)_______________ Tuberculin (TB) Test_______________ Booster_______________

Medications: Be advised: It is important that children remain on their regular medication prior to, and during the week of, the LEAP Summer Program. All medication brought to camp must be in original container with the pharmacy label on it. If allergic to bee stings, please bring your own epinephrine (PEN). Do not bring over the counter medications (Tylenol, Advil, cough syrup, etc.). These will be available through the program nurse. Please add any other comments you would like to convey, related to HEALTH and MEDICATIONS, on an additional sheet.

Does the attending student take any medications? ☐ No ☐ Yes, please fill in the following

1. Name____Dosage:______________________Times:_______________
2. Name____Dosage:______________________Times:_______________
3. Name____Dosage:______________________Times:_______________

(Form continued on next page)

Please return this form to Adoption Option Inc's PO Box Address listed at the top of this page by May 1, 2017

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What is (are) the medication(s) for? ____
____
____
____
____

Medical Release:

This health history is correct so far as I know, and by my signature I am permitting the person listed above (under "Participant Name") to engage in all prescribed program activities, except as noted. The undersigned do hereby authorize the directors of Adoption Option Inc.'s LEAP Summer Program, or such substitute as they may designate as agent for the undersigned, to consent to consent to routine, non-surgical medical care, and to secure emergency medical and surgical treatment for the participant, while involved at the LEAP Summer Program. This authorization will remain effective while participant is en-route to and from or participating in any camp program, unless revoked in writing by the undersigned and delivered to the Director. Note: In accordance with MCLA Act 116 of the Public Acts of 1973, as amended, and the rules for licensing camps this authorization must be signed by a parent/guardian unless there is a religious objection. I also accept financial responsibility for any and all medical treatment that arises out the participant's attendance at the LEAP Summer Program

Signature ____**Date:**____________________

Relationship to Participant____

PLEASE <u>ATTACH A COPY</u> OF THE PARTICIPANT'S IMMUNIZATION HISTORY AND MEDICAID/INSURANCE CARD.

Please mail this form to Adoption Option Inc's PO Box Address listed at the top of this page by May 1, 2017