Office Use Only

HEALTH FORM

Date ____________________
Month / Day / Year

All information on this form is considered confidential. Withholding or falsification of information will absolve Latvian Center Garezers, hereafter referred to as "Garezers"; of any responsibility should complications occur. *Every consideration will be made to accommodate the special needs of each student. However, Garezers reserves the right to reconsider enrollment should issues require support beyond the capabilities of Garezers staff.*

Student / Family Information- (To be completed by parent)
Please include complete information for each line each summer. Indicate "NA", "None" or "Not Applicable" where appropriate. Records from previous years are not transferred to the current year.

Name ______________________________________ Program ____________________
Last First Middle

Date of Birth____________ Age of camper on June 20 _________Sex _______ Grade ___________
Month / Day / Year

New Camper ☐ Returning Camper ☐

Father, Stepfather, Male Guardian (circle one)		**Mother, Stepmother, Female Guardian** (circle one)	
Name	______________________	Name	______________________
Address	______________________	Address	______________________
City/State/Zip	______________________	City/State/Zip	______________________
Country	______________________	Country	______________________
Home Phone	( ) ______________	Home Phone	( ) ______________
Cell Phone	( ) ______________	Cell Phone	( ) ______________
Work Phone	( ) ______________	Work Phone	( ) ______________
Date of Birth	______________________	Date of Birth	______________________
E-mail	______________________	E-mail	______________________

If parents are separated/divorced, please indicate who should be contacted for medical issues: Father ☐ Mother ☐

Health Insurance – All campers are expected to have health insurance while attending Camp.

Have you provided a legible copy of BOTH SIDES of the insurance card? Yes ☐ No ☐

Health Insurance Company ____

Subscriber name______________________________ Relationship to camper __________________

Does insurance cover prescriptions? Yes ☐ No ☐ Co-Pay amount ____________________________

Emergency Contact: List one additional individual NOT listed above in the Father / Mother section, who speaks English, to be contacted in case of an emergency.

Name ________________________ Phone(_____)________________ Relationship ______________

Garezers requires completion of EACH page for EACH student (new and returning) EACH year.

Student's Name ______________________________________ Date of Birth ________________
Month / Day / Year

Medical History (To be completed by parent) Be sure to include complete and thorough information for each line. Please do not leave lines blank.

Please list all known allergies (drugs, food, environmental) ____

Are there any medical problems of which the Camp should be aware? (ie. diabetes, asthma, seizure disorder, etc.)

Yes ☐ No ☐ If yes, please explain in detail. Please attach additional information if necessary.

____

____

Major surgery? Yes ☐ No ☐ Type of surgery performed ____

Any current limitations on activity? Yes ☐ No ☐ Please explain ____

____

Has the camper ever had any of the following? Please check.

	Yes	No		Yes	No		Yes	No
ADD/ADHD	☐	☐	Hay Fever	☐	☐	Menstrual Irregularities	☐	☐
Asthma/Peak Flow____	☐	☐	Headaches (frequent)	☐	☐	Mononucleosis	☐	☐
Chest Pain	☐	☐	Hearing Loss	☐	☐	Rheumatic Fever	☐	☐
Chronic ear condition	☐	☐	Heart Disease	☐	☐	Seizures	☐	☐
Diabetes	☐	☐	Hepatitis (Type _____)	☐	☐	Tendonitis/Muscle Pain	☐	☐
Dizziness with exercise	☐	☐	Hernia	☐	☐	Thyroid Disease	☐	☐
Eating Disorder	☐	☐	Hives	☐	☐	Tuberculosis	☐	☐
Fainting with exercise	☐	☐	Joint/Back Problems	☐	☐	Other ________________________		

Further explain any problems identified above: ____

Is there anything in your religious beliefs that should be given consideration in the treatment of the camper or in case of an emergency? Please explain: ____

Is your child's immunization status up to date (defined below)? Yes ☐ No ☐

Up to Date Immunization Status as defined by the Michigan Department of Community Health is as follows:

- Diphtheria, Tetanus, Pertussis – **4** doses D and T **OR 3** doses Td if first dose given on or after 7 years of age. **1** dose of Tdap for children 11 through 18 years IF **5** years since the last dose of tetanus/diptheria containing vaccine.
- Polio - **3** doses
- Measles, Mumps, Rubella – **2** doses on or after 12 months of age
- Hepatitis B – **3** doses
- Meningococcal – **1** dose for children 11-18 years of age
- Varicella (Chicken Pox) – History of chicken pox illness **OR 2** doses of varicella vaccine at or after 12 months of age **OR** lab immunity

REQUIRED: Date of last tetanus shot __________ and type __________
Month/Day/Year Dtap, Td, or Tdap

MANDATORY ANNUAL EXAM by Licensed Medical Personnel

Height: ________ Weight: _________

Comments:____

I have examined the child herein described and have reviewed the health history. It is my opinion that this camper is physically able to engage in camp activities, except as noted above.

______________________________ ______________________________
Signature of Licensed Medical Personnel Date

Printed name______________________________ Telephone______________________________

Address____

Garezers requires completion of EACH page for EACH student (new and returning) EACH year.

Student's Name ______________________________ Date of Birth ________________
Month / Day / Year

Authorizations - (To be completed by parent. Changes may not be made to the statements below.)

Consent for Treatment and Referral

I hereby consent to any and all diagnostic procedures, examinations, care and treatment as deemed necessary by the Garezers health care provider or designate. I further consent to authorize the Garezers health care provider or designate to refer my child for consultation to any licensed medical personnel or facility as judged necessary and give authority and power to any such provider to render any and all such diagnostic procedures, examinations, care or treatment that he/she may deem necessary or advisable.

I understand that every attempt will be made to contact me prior to sending my child off campus for care.

I understand I will be charged for dental work, prescriptions, antibiotics, glasses, x-rays, consultations and transportation to Three Rivers or elsewhere required for such appointments. Any Garezers faculty or staff member may accompany the student as circumstances warrant, and is authorized to sign the proper permit forms required by the facility.

Serious Accident or Illness

I understand Garezers will make every effort to contact me in case of a serious accident or illness involving my child, while they are in the custody of Garezers or its employees. I understand a situation may arise when emergency treatment may be necessary and I cannot be reached. In such situations, I hereby authorize Garezers personnel to make provisions for treatment with the appropriate medical personnel or facility.

Waivers

I understand and agree that Garezers and its respective directors, trustees, officers, agents, employees and its health care staff will not accept responsibility for the following:

1. Medication not prescribed by an Garezers health care provider and action resulting from its use.
2. Actions of the student contrary to medical advice.

Verification

I certify that every answer that I have given on this form is complete and accurate to the best of my knowledge. I understand that answers to these questions are of vital importance to my child's health care while at Garezers. I answered questions fully and correctly. Garezers reserves the right to dismiss any students (without refund), or to cancel any contract if incorrect information is supplied on this form.

______________________________ ________
Parent or Guardian Signature Date

Student's Name ______________________________ Date of Birth ______________

Authorization for Use of Disclosure of Protected Health Information

I authorize all health care providers to release to the Health Services department of Latvian Center Garezers any and all medical records and other protected health information relating to my child/me, for the purpose of assisting Garezers in fulfilling its responsibilities toward my child/me and toward other persons with whom my child/I may come in contact.

I also give Latvian Center Garezers Health Services, permission to share pertinent information regarding my son/daughter with Garezers faculty and staff. This information will be shared solely to support ongoing care and treatment of my child while at Garezers in order to maintain continuity of my child's care and provide support in all aspects of campus life.

This authorization will expire on September 1, 2014.

I understand the following:

1. I have the right to revoke this authorization at any time before its expiration date by providing written notification of its revocation to the health care provider(s), but revocation will not apply to information which has already been disclosed in response to this authorization;

2. I am not required to sign this form in order for my child to receive health care treatment;

3. The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy rules;

4. A copy of this authorization is as valid as the original.

______________________________ ________
Parent or Guardian Signature Date

Acknowledgement of Review of HIPAA - Notice of Privacy Practices

By signing below, I acknowledge that I have reviewed Latvian Center Garezers' **HIPAA - Notice of Privacy Practices** (see **www.garezers.org** under Summer Programs).

______________________________ ________
Parent or Guardian Signature Date

Student's Name ______________________________________ Date of Birth ________________
Month / Day / Year

Medication Policy and Inventory - (To be completed by parent)

Campers must comply with Garezers policies, nurse or provider instructions, and/or parent wishes concerning the use of medications. Campers are expected to be responsible for picking up medications while at Camp.

Prescription Medication

Please list all prescription medications. Prescription medications must be in original pharmacy containers, labeled by the pharmacy **in English**, with the name of the student, and with current instructions for use and expiration date. Sample medications must be accompanied by written instructions for use from the prescribing provider.
If medicine is taken "as needed" or on class days only this directive MUST appear on the label or additional written documentation from the prescriber is required. Parents are asked to provide enough medication for the duration of the child's stay at Camp.

Medication Name	Reason for Use	Daily?	As Needed?	Directions on Label	Expiration

Non-Prescription Medication

We strongly discourage campers from bringing general over-the-counter medications. Heath Services provides items such as mild pain relievers, cold relief medications, cough suppressants, etc. If you believe your camper must bring his/her special over-the-counter medications, please list them below and include all over-the-counter medications, vitamins, skin preparations, herbal items, food supplements, etc. **These medications must be labeled in English and handed in to Health Office.**

Name of Medication	Reason for Use	Directions on Label

No Medication

Check here to indicate that your child has no medications as described above. _________

Parent Acknowledgement

I acknowledge that I understand that have read Garezers' Medication Policy and that the above information is complete and correct. I understand that sleep aids, stimulants, (such as No-Doze and high caffeine beverages), and diet aids are not allowed without written physician permission and that these medications will be kept and monitored by Health Services personnel.
The responses on this Health Form are true and correct to the best of my knowledge.

Parent Signature: ____

Student Signature: ____

Date: ______________________

Page Intentionally Left Blank

Camper Profile Form

Is your child currently under the care of a provider, counselor, or mental health therapist for mental health counseling or therapy? Yes ☐ No ☐

If the above answer is "yes", this professional **MUST** complete the **Camper Profile Form** on pages 7 and 8 of this document. This information is confidential.

Name ______________________________ Date of Birth ______________________
Month / Day / Year

Section I - Completed by Parent:

☐ Male ☐ Youth camp Dates of Attendance __________________ ☐ New Camper

☐ Female ☐ Intermediate Dates of Attendance __________________ ☐ Returning Camper

☐ High School Dates of Attendance __________________

I hereby consent to and authorize the staff of the Latvian Center Garezers to communicate with and receive communication from the above named camper's physician, nurse, psychiatrist, psychologist, social worker or licensed professional counselor.

______________________ ______________________ ____________

Parent Printed Name Signature Date

Section II – Completed by Physician or Therapist:

Length of time in counseling ____________________ Date last seen by therapist________________

1. Presenting problems:

2. Diagnosis:

3. List all medications (if applicable):

4. Treatment plan:

5. This camper has been hospitalized for depression and/or other emotional conditions.

   ☐ No

   ☐ Yes Date hospitalized ___________________ Length of stay ________________

   Diagnosis____

6. This camper has been diagnosed with an eating disorder.

   ☐ No

   ☐ Yes Date diagnosed ___________________

   Diagnosis____

Garezers requires completion of EACH page for EACH student (new and returning) EACH year.

8. Please list accommodations and/or support this camper might need from the <u>professional staff</u>:
   - ☐ None Needed
   - ☐ Accommodations to be considered:

9. Additional Comments:

10. Please call me for additional information.
    - ☐ No
    - ☐ Yes

The above information will be held in strict confidence and will be shared only with appropriate professional personnel.

Please print the following:

____

Provider's Printed Name Date

____

Provider's Printed Name

____

City State Zip

____

Phone Fax E-mail address

Garezers requires completion of EACH page for EACH student (new and returning) EACH year.