

SESSION # 4 (July - 20 )

**Complete and Return to: Stacey Dreesen**  
4608 West 87<sup>th</sup> Street  
31246 457<sup>th</sup> Ave  
Chicago, IL 60652  
Or E-mail to: [smloen@hotmail.com](mailto:smloen@hotmail.com)

**CONFIDENTIALITY AND SECURITY OF INFORMATION –  
PROTECTED HEALTH INFORMATION**

We restrict access to non-public personal information to those employees who need to know that information to provide services to you and your child. Health forms are secured in either the main office or the Health Director’s office until the end of summer camp season, and then they are stored in the camp archives.

**CAMPER HEALTH HISTORY & INSURANCE  
INFORMATION**

**Parents fill out Parts A,B,C,D,E,F**

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**PART A: CAMPER INFORMATION**

Camper’s Name \_\_\_\_\_ D.O.B. \_\_\_\_\_  
Address \_\_\_\_\_  
(City) (State) (Zip)  
Home Phone \_\_\_\_\_ Emergency Daytime Phone \_\_\_\_\_  
E-mail contact \_\_\_\_\_  
T-Shirt Size (indicate child or adult) \_\_\_\_\_

**\*\*\*IF PARENT CANNOT BE REACHED, OTHER PERSON(S) TO CONTACT WHILE  
CAMPER IS AT CAMP\*\*\***

1. Name \_\_\_\_\_  
Day Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_  
Address \_\_\_\_\_  
(City) (State) (Zip)
2. Name \_\_\_\_\_  
Day Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_  
Address \_\_\_\_\_  
(City) (State) (Zip)



IF YES, PLEASE DESCRIBE

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Immunization History (please be as accurate as possible with dates)**

\_\_\_\_\_ DPT Series                      \_\_\_\_\_ BOOSTER                      \_\_\_\_\_ TETANUS BOOSTER  
\_\_\_\_\_ POLIO OPV (Sabin)              \_\_\_\_\_ BOOSTER                      \_\_\_\_\_ TUBERCULIN TEST  
\_\_\_\_\_ MMR

OTHER (please list)

\_\_\_\_\_

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**PART D: PARENT'S AUTHORIZATION**

I hereby give permission to the medical personnel selected by the camp director to provide routine health care; to administer medications; to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physicians selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. Camp Foster YMCA will make every attempt to notify you before making a doctor's appointment or an emergency room visit for your child while they are in our care. All minor medical needs will be cared for by the on-site Health Director without notification to parents.

**X**

\_\_\_\_\_  
(Signature Parent/Guardian)

\_\_\_\_\_  
Date

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**PART E: INSURANCE/HOSPITAL REGISTRATION INFORMATION**

**\*\*A COPY OF BOTH SIDES OF YOUR INSURANCE CARD  
NEEDS TO BE ATTACHED TO THIS FORM!**

Camper's Name \_\_\_\_\_ Gender ( M / F ) D.O.B \_\_\_\_\_  
Address \_\_\_\_\_  
(City) (State) (Zip)

Father's Name \_\_\_\_\_ Soc. Sec # \_\_\_\_\_  
Father's Address \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Father's Employer \_\_\_\_\_

Mother's Name \_\_\_\_\_ Soc. Sec # \_\_\_\_\_  
Mother's Address \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Mother's Employer \_\_\_\_\_

Family Doctor \_\_\_\_\_  
Phone # \_\_\_\_\_

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**INSURANCE INFORMATION**

DO YOU HAVE:

\_\_\_\_\_ TITLE XIX \_\_\_\_\_ MEDICAID  
\_\_\_\_\_ NO INSURANCE COVERAGE

PLEASE LIST YOUR CARD NUMBER

\_\_\_\_\_

**\*\*PLEASE ATTACH A COPY OF YOUR INSURANCE CARD OR TITLE XIX CARD**

If you have other insurance, please write name and address of insurance company

\_\_\_\_\_

Is this coverage through: \_\_\_\_\_ Group/Father Employer \_\_\_\_\_ Group/Mother Employer  
\_\_\_\_\_ Individual Policy \_\_\_\_\_ Other \_\_\_\_\_

Policy Number \_\_\_\_\_

Group Number \_\_\_\_\_

If you have secondary coverage, please provide this information:

INSURANCE COMPANY \_\_\_\_\_

ADDRESS \_\_\_\_\_

\_\_\_\_\_

POLICY OWNER \_\_\_\_\_ POLICY NUMBER \_\_\_\_\_

GROUP NUMBER \_\_\_\_\_

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**RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS**

I authorize Spirit Lake Medical Center or Lakes Family Practice and associated physicians to release to the Medicare carriers or the insurance carrier listed above, any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts the assignment on all future claims. I understand that I am financially responsible for all charges incurred.

**X** \_\_\_\_\_

Parent/Primary Insured Signature

Date

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**Part F: Photograph/video Release**

Miracle Burn Camp of Iowa is sponsored by several area and local sponsorships. Photographs and video will be taken at camp to assist with obtaining future camp funding (generally in the form of brochures and literature). Often, as people become aware of how to prevent burns, they want to support programs that help survivors of burn injuries. We do need your authorization in order to take any photographs or video footage, so please check the appropriate statement below. Thanks!

\_\_\_\_\_ YES, I AUTHORIZE MIRACLE BURN CAMP/CAMP FOSTER YMCA TO USE PHOTOGRAPHS/VIDEO FROM CAMP FOR PUBLIC EDUCATION TO PREVENT BURNS. I UNDERSTAND THAT THE LAST NAME, CIRCUMSTANCES OF THE BURN INJURY AND ANY OTHER SENSITIVE PERSONAL INFORMATION WILL NOT BE REVEALED WITHOUT FURTHER, SPECIFIC CONSENT.

\_\_\_\_\_ NO, I DO NOT WISH TO HAVE MY CHILD PHOTOGRAPHED OR VIDEOTAPED IN ANY WAY WHILE AT MIRACLE BURN CAMP.

Parent/Guardian Signature X\_\_\_\_\_

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**PART G: MEDICAL EXAMINATION (To be completed by physician)**

\*\*\* The Medical Examination section must be completed by a licensed physician before attending camp. If a camper has had a general examination for any other reason within the past 24 months, a copy of that health record can be attached.

HGT\_\_\_\_\_ WGT\_\_\_\_\_ B.P.\_\_\_\_\_ EYES\_\_\_\_\_
GLASSES\_\_\_\_\_ EARS\_\_\_\_\_ NOSE\_\_\_\_\_
THROAT\_\_\_\_\_ TEETH\_\_\_\_\_ SKIN\_\_\_\_\_
POSTURE/SPINE\_\_\_\_\_ HEART\_\_\_\_\_ LUNGS\_\_\_\_\_
HERNIA\_\_\_\_\_ ABDOMEN\_\_\_\_\_ EXTREMITIES\_\_\_\_\_
ALLERGIES (Specify)\_\_\_\_\_
FEMALES: MENSTRUAL HISTORY NORMAL\_\_\_\_\_
SPECIAL CONSIDERATIONS\_\_\_\_\_
RESTRICTIONS/RECOMMENDATIONS WHILE AT CAMP\_\_\_\_\_

SPECIAL DIET (Specify)\_\_\_\_\_
SWIMMING/DIVING\_\_\_\_\_
STRENUOUS ACTIVITY\_\_\_\_\_
OTHER\_\_\_\_\_

\*\*\*\*\*

I HAVE EXAMINED THE PERSON DESCRIBED AND HAVE REVIEWED HIS/HER HEALTH HISTORY. IT IS MY OPINION THAT HE/SHE IS PHYSICALLY ABLE TO ENGAGE IN CAMP ACTIVITIES, EXCEPT AS NOTED.

X\_\_\_\_\_
PHYSICIAN SIGNATURE DATE

X\_\_\_\_\_
PARENT/GUARDIAN SIGNATURE DATE