

Instructions for Camp Arcadia Teen Week Forms

Thank you in advance for filling out your teen's forms for their Camp Arcadia teen weeks. These forms will help us serve your child, so please fill them out completely and accurately.

- These forms are needed on file at Camp Arcadia by May 15th. The forms can be completed and returned to camp anytime between now and May 15th, 2010.
- Note that signatures are required on the Heath History Record, the Child Information Record and the Camper Payment Form.
- On the Heath History Record, all immunizations are not required in order for your teen to attend camp. Simply complete the immunization information to the best of your knowledge.
- Credit card information on the Camper Payment Form cannot be entered into the form on the computer. Fill in this information after printing the form.
- The mailing address for these forms is Camp Arcadia, PO Box 229, Arcadia MI 49613. We cannot accept faxed copies of these forms, so they must be mailed to us.

Thanks so much! Please call or email us with questions.

Mike Pasche
Director of Business

email: camp-arcadia@camp-arcadia.com
camp phone: (231) 889-4361



HEALTH HISTORY RECORD

Michigan Department of Human Services

Dear Authorized Person:

The following information is request so that the Camp can better meet the physical, intellectual, and emotional needs of the camper. Fill out the information requested. (Use back of form if additional space is required.) "Authorized person" means a parent, guardian, or adult camper's designee.

Camper's Name (Last)	First	Middle	Sex	Date of Birth
Address (Number and Street)		City	Zip	Telephone (Home)
Authorized Person's Name (Last)	First	Middle	Telephone (Work)	
Address (Number and Street)		City	Zip	Telephone (Emergency)

Is the camper having any of the problems listed below?	Yes	No		Yes	No
1. Hay fever, asthma, or wheezing	<input type="checkbox"/>	<input type="checkbox"/>	7. Trouble with passing urine or bowel movements	<input type="checkbox"/>	<input type="checkbox"/>
2. Eczema or frequent skin rashes	<input type="checkbox"/>	<input type="checkbox"/>	8. Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
3. Convulsions/seizures	<input type="checkbox"/>	<input type="checkbox"/>	9. Speech problems	<input type="checkbox"/>	<input type="checkbox"/>
4. Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	10. Menstrual Problems	<input type="checkbox"/>	<input type="checkbox"/>
5. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	11. Dental problems	<input type="checkbox"/>	<input type="checkbox"/>
6. Frequent colds, sore, throats, ear aches (4 or more per Year)	<input type="checkbox"/>	<input type="checkbox"/>	12. Other	<input type="checkbox"/>	<input type="checkbox"/>

Please explain any problem areas identified above including any current infectious diseases:

If female has she been told about menstruation (answer if appropriate) <input type="checkbox"/> Yes <input type="checkbox"/> No	Has she menstruated (answer if appropriate) <input type="checkbox"/> Yes <input type="checkbox"/> No
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Operations or Injuries

Explain Any Special Health, Behavioral or Emotional Consideration(s)

Medication Needed or Used (Including Psychiatric)			Currently Being Given	
Kind	Frequency	Dosage	Yes	No
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

Special conditions to be watched for such as ALLERGY (Reactions to food, Penicillin or other drugs), Bedwetting, Fainting, Sleep Walking, etc.

IMMUNIZATION		Polio	Mumps	Diphtheria	Tetanus	Pertussis (Whooping cough)	Measles	Rubella	Hepatitis B	Other	
	Date Initial Immunization Completed										
	Date of Most Recent Booster										

Should the camper's activity be restricted because of any physical limitation or illness? No Yes If yes, explain degree of restriction:

I give Camp Arcadia's nurse permission to give my child Tylenol as she/he deems it appropriate. No Yes.

I certify that this information is true to the best of my knowledge. Authorized Person's Signature _____ Date _____



The Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your county.

**CHILD INFORMATION RECORD
STATE OF MICHIGAN
Department of Human Services
Bureau of Children and Adult Licensing**

Date of Admission		Allergies		<p align="center">CHILD INFORMATION RECORD STATE OF MICHIGAN Department of Human Services Bureau of Children and Adult Licensing</p>							
Date of Discharge											
Name of Child (Last, First, Middle Initial)								Address (Number and Street, Building/Apartment Number)			
Child's Date of Birth		Home Phone ()						City		State	Zip Code
Father/Legal Guardian's Name		Home Phone						Mother/Legal Guardian's Name		Home Phone	
Home Address (if not child's address)		Cell Phone						Home Address (if not child's address)		Cell Phone	
City	State	Zip Code	City					State	Zip Code		
Employer/School Name								Employer/School Name			
Address (Employer/School)								Address (Employer/School)			
City	State	Zip Code						City	State	Zip Code	
Employer/School Phone		Daily Work/School Times		Employer/School Phone ()		Daily Work/School Times					
Name(s) of Person other than Parent or Legal Guardian to whom child may be released											

BCAL-3731 (Rev. 3-08) Previous edition may be used.

I give permission to <u>Lutheran Camp Association (Camp Arcadia)</u> , licensed by the Department of Human Services (Provider's Name)				
to secure emergency medical and/or emergency surgical treatment for the above named minor child while in care.				
Signature of Parent or Guardian			Date Signed	
Name of Child's Physician or Health Clinic		Physician's or Health Clinic's Phone Number ()		
Address of Child's Physician or Health Clinic		Name of Health Insurance Carrier		
Hospital Preferred for Emergency Treatment		Health Insurance Policy Number		
Special Needs:		Date of Last DTaP (Diphtheria, tetanus, pertussis) Shot		
Name of Local Person to be Notified in an Emergency When Parents Not Available		Local Address of Emergency Person		
Home and/or Cell Phone ()	Work Number ()	City, State		Zip code
Special Instructions:				
Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, sexual orientation, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.			AUTHORITY: 1973 PA 116 COMPLETION: Required PENALTY: Rule Violation Citation.	

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Camper's Name _____ Attendance Date _____

Camper Payment

Camp Arcadia Teen Retreats

Charges for balance of registration fee, camper spending account and highlight DVDs will be made through one credit card payment prior to arrival. Please complete this form and return it to Camp prior to May 15th. If necessary, special arrangements may be made for alternate payment methods by contacting the Camp office.

Balance of registration fee: _____ (Required) \$295 minus the deposit made at time of registration.

Spending Account: _____ (Optional) Generally, students use between \$50 and \$100. The balance of this account is fully reimbursed at the end of the week or may be left in the account and thus donated to the Camp Arcadia scholarship fund.

Highlight DVD: _____ (Optional) The cost of this is \$10. We will compile a highlight DVD of the week and have it ready on Saturday, the day of check out.

Total of the above: _____ This is the amount to be charged on the below credit card.

--> Print out the form and then fill out the credit card information. Mail forms to Camp Arcadia.

Visa, Mastercard and Discover payment:

Card Number _____ - _____ - _____ - _____ exp date: ____ / ____ (mm/yy)

3 Digit Security Code: _____

Billing address is same as camper address

Different credit card billing address: _____

Name on Card: _____

Signature: _____

