

SPIRIT OF AMERICA PARTICIPANT HEALTH FORM

Please Return to: Camp Foster YMCA PO Box 296 Spirit Lake, IA 51360

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 the main office until the end of the camp, and then will be filed and stored for up to two years.

PARTICIPANT'S HEALTH HISTORY & INSURANCE INFORMATION Parents, Please fill out Parts A,B,C,D,E (on back)

PART A PARTICIPANT'S INFORMATION

Participant's Name _____ D.O.B. _____

Address _____

Home Phone _____ (City) _____ (State) _____ (Zip) _____
Emergency Daytime Phone _____

**IF PARENT CANNOT BE REACHED, LIST 2 CONTACTS WHILE PARTICIPATING WITH SPIRIT OF AMERICA

1. Name _____ Day Phone _____
Address _____ Evening Phone _____

2. Name _____ Day Phone _____
Address _____ Evening Phone _____

PART B HEALTH HISTORY (check all that apply, and give approximate dates, if possible)

ALLERGIES

- _____ Hayfever
- _____ Poison Ivy, etc
- _____ Insect Stings
- _____ Penicillin
- _____ Peanuts, Nuts
- _____ **Other food or drugs

DISEASES OR HEALTH CONCERNS

- | | | |
|-------------------|-----------------------|----------------------|
| _____ Chicken Pox | _____ Ear Infection | _____ Migraines |
| _____ Measles | _____ Rheumatic Fever | _____ Nosebleeds |
| _____ Convulsions | _____ German Measles | _____ Braces |
| _____ Mumps | _____ Diabetes | _____ Heart Murmur |
| _____ Asthma | _____ Behavior | _____ Contact Lenses |
| | _____ Eczema | _____ Hives |

**Specify _____
Other Health concerns or details of any above _____

Operations/Serious Injuries (Date & Explanation) _____

Medications the camper will be taking during Spirit of America:

MEDICATION NAME	DOSAGE	REASON FOR MEDICATION
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PART C IMMUNIZATION HISTORY (Please list dates as accurate as possible)

_____ DPT Series _____ BOOSTER _____ TETANUS BOOSTER _____ MMR
_____ POLIO OPV (Sabin) _____ BOOSTER _____ TUBERCULIN TEST _____ OTHER (please list) _____

PART D PARENT'S AUTHORIZATION

I hereby give permission to the medical personnel selected by the Spirit of America's 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 SOA director to secure and administer treatment, including hospitalization, for the person named above. Spirit of America 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 Volunteer Director without notification to parents. Spirit of America has my permission to use any photographs taken of my child for promotional material only.

Signature - Parent/Guardian _____

Date _____

PART E INSURANCE/HOSPITAL REGISTRATION INFORMATION

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

Participant's Name _____ Gender (M / F) Birthdate _____

Address _____ (City) _____ (State) _____ (Zip) _____

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

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

Family Doctor _____ Phone # _____

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 _____

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.

Parent/Primary Insured Signature _____

Date _____

Updated 02/04/09 jpr

