Camp Winnekeag

Health History and Examination for Camper/Staff

Directions

1) **Sections 1, 2, & 3** must be completed by parent/guardian of minor (or by adult camper/staff 18 or older for themselves). (Each year)
2) **Section 4** must be completed and signed by examining physician (Every 24 months)
   (*If for religious reasons, you cannot do sections 3 and 4, contact (978) 365-4551 x 620 for a legal waiver which must be signed for attendance.)
3) **BRING THIS FORM TO CAMP. DO NOT MAIL.**

❶ Personal & Emergency Contact Information

Camper/Staff Name _____ Gender M F Birth Date _____ Age _____

Home Address _____
Street Address *City* *State* *Zip Code*

Parent/Guardian Name _____ Email Address _____

Home Address _____
(If different from above) *Street Address* *City* *State* *Zip Code*

Home Phone (____)_____ Cell Phone (____)_____ Work Phone (____)_____

Second Parent/Guardian Name _____ Email Address _____

Home Phone (____)_____ Cell Phone (____)_____ Work Phone (____)_____

Additional contact in event parent(s)/guardian(s) cannot be reached:

Name _____ Relationship to Camper: _____ Phone (____)_____

❷ Allergies/Health History/Medical Insurance

Allergies: ❑ No known allergies. ❑ This camper/staff is allergic to: ❑ Environment (e.g., insect bites, sun) ❑ Food ❑ Medicine ❑ Other
(Please describe below what the camper is allergic to and their typical reaction.)

Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.

Has/does the camper/staff:

1)	Ever been hospitalized?	❑ Yes ❑ No	11)	Had fainting or dizziness?	❑ Yes ❑ No
2)	Ever had surgery?	❑ Yes ❑ No	12)	Passed out/had chest pain during exercise?	❑ Yes ❑ No
3)	Have a recurrent/chronic illness?	❑ Yes ❑ No	13)	Had mononucleosis during the past 12 months?	❑ Yes ❑ No
4)	Had a recent infectious disease?	❑ Yes ❑ No	14)	Traveled outside the U.S. in the past 9 months?	❑ Yes ❑ No
5)	Had a recent injury?	❑ Yes ❑ No	15)	Have problems with falling asleep/sleepwalking?	❑ Yes ❑ No
6)	Had asthma/wheezing/shortness of breath?	❑ Yes ❑ No	16)	Ever had back/joint problems?	❑ Yes ❑ No
7)	Have diabetes?	❑ Yes ❑ No	17)	Have a history of bedwetting?	❑ Yes ❑ No
8)	Had seizures?	❑ Yes ❑ No	18)	Have problems with diarrhea/constipation?	❑ Yes ❑ No
9)	Had headaches?	❑ Yes ❑ No	19)	Have any skin problems?	❑ Yes ❑ No
10)	Have impaired vision?	❑ Yes ❑ No	20)	If female, have problems with menstrual cycle?	❑ Yes ❑ No

Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

Does camper/staff have any current physical, medical, or psychological conditions requiring medication, treatment, or special considerations or activity restrictions while at camp? ❑ Yes ❑ No If yes, please explain below:

Medical Insurance Information/ Health-Care Providers:

Insurance Company _____ Policy #_____ Group #_____

Name of camper's primary doctor: _____ Phone (____)_____

MEDICAL INFORMATION: PLEASE READ CAREFULLY THEN COMPLETE CONSENT SECTION

In planning for the camping season we have endeavored to create as safe an environment as possible while allowing campers to experience adventure through a variety of activities and by choice physical challenges. In the event a camper needs medical attention, the accompanying **consent to medical treatment** will be used**. It must be completed and signed before the camper is accepted. This form must arrive at camp with the camper.** When your child's camp application is processed, an acceptance letter will be sent along with a consent **to administer medications** form. If your child is taking medication, this form is mandatory. These completed forms must be presented to the Director of Nurses upon arrival at camp. **If these forms are incomplete, your child will not be permitted to remain at camp.** A licensed nurse will be on site at all times during the camping season. Nurses will be available during camper registration to perform a health evaluation on each camper. **Please plan to wait until your child is approved to remain at camp.** In addition, camper medications will be collected by the nurse at this time. **All prescription drugs or over-the-counter medications must be in the original bottle or packaging, showing the camper's name, dosage, frequency, etc. This also applies to herbal drugs.** In the event of an emergency, the camp will make every attempt to contact the parent or legal guardian.

❸ Consent to Medical Treatment & Authorization to Release Information

This health history, found on page 1 of this form, is correct and accurately reflects the health status of the individual to whom it pertains. My signature below indicates that I am giving my consent for any x-ray, examination, anesthetic, medical or surgical diagnosis of treatment, medications (over the counter and otherwise prescribed) and hospital service that may be rendered to individual named herein under the general or special instructions of the primary physician listed above or any physician the camp may call, whether such diagnosis or treatment is rendered at the office of said physician, at a licensed hospital, or at the camp. I also authorize the licensed nurse at Camp Winnekeag to initiate first treatment when medical attention is required according to camp guidelines and protocols. It is understood in the case of a major accident or illness, reasonable effort will be made to reach the doctor listed above before any other physician is called by the camp. It is further understood that this consent is given in advance of any specific diagnosis or treatment which might be required and is given to authorize Camp Winnekeag or the physician to exercise his/her best judgment as to the requirements of such diagnosis or treatment.

This consent shall remain in continuous effect until revoked in writing or until said individual's summer camp stay has ended. We/I hereby authorize any hospital or physician, or any other person who attended to or examined this individual to furnish Camp Winnekeag's insurance company or its representative any and all information with respect to any illness, medical history or consultation, prescriptions or treatment, and copies of all hospital or medical records. A photocopy of this form shall be considered as effective and valid as the original.

Camper/Staff Name _____

Signature of Parent or Guardian (or an Adult Camper/Staff Member) _____ Date_____

Witness Signature _____ Date_____

❹ Physical Examination - To be completed and signed by licensed physician.

Physical examination is valid for 24 months, and must be current on 1st day of camp, a copy must be brought each year to camp.)

Camper/Staff Name _____ Age_____ Gender M F

Height _____ Weight_____ Blood Pressure _____ Hgb. Test_____ Urinalysis_____

Eyes _____ Ears_____ Nose_____ Throat_____ Neck_____ Teeth_____

Lungs_____ Abdomen_____ Hernia_____ Extremities_____ Spine_____

Heart_____ Skin_____ Ano-Genital_____ Cranial Nerve_____ Mouth_____

List All Known Allergies _____

General Appraisal _____

For Females: Has this person menstruated?_____ If not, has she been told about it? _____ If so, is menstrual history normal? _____

Special Considerations/Medical Notes: (Please list all medications, any restrictions, health problems, recent injuries, etc.)

Immunizations: Provide the month and year for each immunization.

Vaccines		Month /Year	Month /Year	Month /Year	Month /Year	Month /Year
Diptheria, tetanus, pertussis (DTaP) or (TdaP)						
Tetanus booster (dT) or (TdaP)						
Mumps, measles, rubella (MMR)						
Polio (IPV)						
Hepatitis B						
Varicella (chicken pox)	❑ Had chicken pox Date:					

I have examined the person named herein described and have reviewed his/her health history. It is my opinion that he/she is able to physically engage in camp activities except as noted above.

Physician's Signature_____ Telephone Number _____

Physician's Name & Address_____ Date_____