HEALTH HISTORY & EMERGENCY INFORMATION

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PARENTS, YOUR CHILD CANNOT ATTEND CAMP WITHOUT HEALTH HISTORY & PHYSICIANS FORM!

Camper's Name ____
(first) (middle) (last)

Age ___________ **Sex M F** **Birthdate** _____/_____/_____

Parent/Guardian Name ____
Address ____
City ______________________ **State** _________ **Zip** ____________
Phone: Home (_____) ______ - ___________ **Bus/Cell** (_____) ______ - ___________

Parent/Guardian Name ____
Address ____
City ______________________ **State** _________ **Zip** ____________
Phone: Home (_____) ______ - ___________ **Bus/Cell** (_____) ______ - ___________

Local Emergency Contact/Pick-Up other than Parents:______________________________
____
Phone: Home (_____) ______ - ___________ **Bus/Cell** (_____) ______ - ___________
Relationship: ____

Health and Medications

Significant Health Concerns: ____
____
Medications to be administered at Camp*:____
____
Medications given at home: ____
____
Limitations in any activities?____
Other information: ____

* Medications must be brought to camp in the original labeled pharmacy container. Parents also must sign consent forms prior to any medication being administered.

Please check all that apply:

- ❑ Drug Allergies: ____________________
- ❑ Food Allergies: ____________________
- ❑ Foods poorly tolerated: ____________________

____

- ❑ Dietary preferences (circle): Vegetarian, No Dairy, Other ____________
- ❑ Environmental Allergy: ____________________
- ❑ Bee Sting Allergy
- ❑ Severe Allergic Reactions to: ____________________

____

- ❑ Epinephrine pen is prescribed.
- ❑ Asthma
- ❑ Diabetes
- ❑ Seizure Disorder
- ❑ Heart Problems
- ❑ Infectious Diseases
- ❑ Bleeding/Clotting Disorders
- ❑ Bowel/Bladder Problems
- ❑ Fears/Phobias
- ❑ Attention Deficit Disorder
- ❑ Other______________________________

____
____
____

Name of Physician: ____________________
Phone: ____________________
Do you carry family medical/hospital insurance: Y N
If so, who is the carrier? ____________________
Policy or Group #: ____________________
Hospital Preference:____________________

Name of Dentist: ____________________
Phone: ____________________
Name of Orthodontist: ____________________
Phone: ____________________

Important - This MUST be signed and completed to qualify for camp

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed activities except as noted. Emergency Authorization: I hereby give permission to the medical personnel selected by the camp director to order xrays, routine tests and treatment for my child, and, in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the director to hospitalize, secure proper treatment for, order injection and/or anesthesia and/or surgery for my child as named above.

I consent to have my child received Tylenol ______ Motrin ______ Benadryl ______ per standing orders. Please initial each medication the nurse may administer.

Signature of Parent or Guardian: ______________________________________ **Date:** _______/_______/_______

I also understand and agree to abide with the restrictions placed on my summer program activities.

Signature of Minor: ______________________________________

PLEASE COMPLETE OTHER SIDE

PHYSICIAN'S FORM

PHYSICIAN COMPLETES THIS FORM
CHILD CANNOT ATTEND WITHOUT COMPLETED FORM

Camper's Name ____
(first) **(middle)** **(last)**

Age _______________ **Sex M F** **Birthdate** _____/_____/______

Health Examination by a Licensed Physician

I have examined the above applicant _______ **Date examined:**_____/_____/______

In my opinion, the named camper's condition does ______ **does not** _____ **preclude his/her participation in an active summer program.**

Current medical problems, recent injuries, operations or chronic conditions:

____
____

Regular and/or periodic medications and reasons for taking them:

____
____

Medically prescribed meal plan or dietary restrictions:

____
____

Allergies (food, drug, environmental, etc.):

____
____

Is an epinephrine pen prescribed: Yes_____ **No**_____

Medications or treatment to be administered during the camp day:

____
____

Outdoor Games participation: This individual may participate in all camp and athletic activities unless otherwise indicated. Limiting conditions:

____
____

Additional Health Information:

____
____
____

Provider's Name: ____
Licensed Provider's Signature:__________________________________
Address: _______________________________ **City:**________________
State: ______ **Zip:** _____________ **Phone:** _(_____)___________________
Date of form completion:_____/_____/______

By____
(Initial if completed by nurse or physician's assistant)

Note: An equivalent form may be utilized. Your child's physical exam must have occured within two years of their first day of camp.

Please record the date (month, date, year) of all basic immunizations and booster doses:

Vaccines		Year of Basic Immunization	Year of last booster
DPT/DTaP	1	________	________
	2	________	________
	3	________	________
	4	________	________
OR	5	________	________
DPT/DTaP		________	________
OR			
Tetanus		________	________
Polio OPV/O{V	1	________	________
	2	________	________
	3	________	________
	4	________	________
MMR (Measles, Mumps, Rubella)		________	________
Measles		________	________
Mumps		________	________
Rubella (German Measles)		________	________
Varicella		________	________
HIB			
Hepatitis B	1	________	________
	2	________	________
	3	________	________
Tuberculin Test	type ________		
	date ________		
	result ________		

Your physician can fax this form directly to Camp Woodhaven at: 508-835-0910 or email this form to: info@campwoodhaven.com