Camp Wilmot, Inc: Health Information

Please fill this out completely, and have authorized physician fills out and signs as indicated. **Bring this completed form with you** to Camp this summer to hand in at registration with remaining camp fee. Thank you.

Questions? Call Shannon Croteau 603-329-4585

Personal Information: To be filled out by parent or guardian

Name: ______________________________________
Last First Initial

Birthdate: ______________ Age: ________ Gender: ☐ M ☐ F Email: ______________________

Home Address: ____
Street and Number City State Zip

Mother/ Guardian: ______________________________ Phone: Hm ( ) ________
Cell ( ) ________ Wk ( ) ________

Father/ Guardian: ______________________________ Phone: Hm ( ) ________
Cell ( ) ________ Wk ( ) ________

Child lives with: ☐ Mother ☐ Father ☐ Other (specify): ______________________

Emergency Contacts:

#1 Paste Photo Here (optional) *(if authorized to pick up child in case of emergency)*	1. Name ______ Phone (___) ______ Address ______ Authorized for emergency pickup? Y/N 2. Name ______ Phone (___) ______ Address ______ Authorized for emergency pickup? Y/N	#2 Paste Photo Here (optional) *(if authorized to pick up child in case of emergency)*

Family Physician name: ______________________ Phone: ____________
Dentist/orthodontist name: ______________________ Phone: ____________

The following person is legally restricted from seeing this camper: ______________
Relationship: ______________

Please inform us in writing of any travel plans you have during your child's stay at Camp Wilmot. Please attach phone numbers, local relative names and numbers, and/or any other information that would assist us in contacting you in case of emergency. Thank you.

Health Insurance Information Is the participant covered by family medical/hospital insurance? ☐ Yes ☐ No

Carrier or Plan Name: Group Number:

Insurance Company Phone Number: Policy Holder:

Policy Holder's SSN or Insurance ID #: Relationship to participant:

If possible, please attach a copy of both sides of your insurance card to this form. Thank you.

Health History - To be filled out by parent/ guardian

Allergies: *(list name and reaction)*

- ❑ No known allergies

Dietary Restrictions: ❑ None

Medications *(list name and dose, including over the counter drugs and dietary supplements)*

- ❑ None

All medications will be registered with the Camp Health Center upon check-in. Medications must be in their original labeled container that identifies the child's name, prescribing physician, name of medication, dosage and frequency of administration. Please bring enough medication to last the entire stay at camp. Thank you.

Medical Problems *(please check those that apply)*

- ❑ Asthma
- ❑ Bleeding disorder
- ❑ Chickenpox
- ❑ Musculoskeletal abnormalities
- ❑ Recent hospitalization
- ❑ Diabetes
- ❑ Hypertension
- ❑ Tuberculosis
- ❑ Liver disease
- ❑ Infectious illness within past 3 weeks
- ❑ Seizure disorder
- ❑ Renal disease
- ❑ Visual problems
- ❑ Absence of eye/ kidney
- ❑ Heart disease
- ❑ Immunodeficiency
- ❑ Hearing deficits
- ❑ Other

If you checked any of the above boxes, please explain, including dates and relevant treatments:

Immunization History *(please provide dates for the following)*

DTaP	_______	_______	_______	_______
Polio	_______	_______	_______	_______
MMR	_______	_______		
Hib	_______	_______	_______	_______
Varicella	_______	_______		
Hep B	_______	_______	_______	
ppD	_______	Result:	_______	
Other:				

Td ___________

Laboratory Testing:

	Date	Result
Hct	_____	_________
G6PD	_____	_________
Lead	_____	_________
Sickle Cell	_____	_________

Medical Authorization and Waiver—Must be signed by Parent or Guardian

I give my permission for my child to engage in all prescribed camp activities, except as noted. I will make sure my child understands and agrees to abide by the restrictions noted on camp activities. I am aware that my child may be transported by bus or other vehicles authorized by Camp Wilmot Inc. for approved trips out of camp/off-site activities. This completed form may be photocopied for trips out of camp/ off-site.

I expect that my child will be well supervised during camp activities. I realize that individuals at camp can injure themselves at camp without fault on the part of Camp Wilmot Inc. personnel. I release Camp Wilmot Inc. from responsibility for injury to my child.

If my child is to take medication, I will instruct my child to take responsibility for going to the Health Center at scheduled times for this purpose.

I hereby give permission to medical personnel selected by the Camp Director to order X-rays, routine tests, and treatments; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child (or me as a staff/volunteer).

In case of emergency, I understand that every effort will be made to contact parents or guardians of the camper. In the event that I cannot be reached, I hereby give permission to the physician selected by the Camp Director to hospitalize, secure treatment for, and to order injection, anesthesia, or surgery for my child as named herein. I hereby authorize the Camp Director and staff to act for me, and on my behalf, according to their best judgment, in any emergency requiring medical attention to be administered to my child, until such time as I may be contacted. I give permission for the Camp Wilmot Health Center Coordinator, or other designated staff member, to administer authorized medication and/or first aid and/or emergency treatment to my child during the camp/program session.

I understand that primary health and accident insurance protection are my responsibility.

I give permission on behalf of my child for the use of photographs, video recordings, and audio recordings taken while at camp and quotations from evaluations/letters related to camp experiences to be used in Camp Wilmot publicity, including camp website.

I understand that at the discretion of the Camp Director and staff, my child may be dismissed from camps/programs, without refund, for inappropriate behavior, which includes, but is not limited to: the possession and/or use of alcohol, tobacco products, illegal narcotics, fireworks, or weapons; violence towards others; public nudity; and/or cohabitation.

I represent and agree that my child is in good health and physical condition and able to fully participated in the entire camp program.

I have indicated any special health, medical or physical condition, including any required medication and activity limitations which should be known to the camp staff, director, emergency medical personnel, doctors or nurses.

In signing this application, I hereby certify that I have read and understood the above statements and attest that the information that I have supplied on this form is correct to the best of my knowledge.

Signature or Parent/Guardian (or adult staff/volunteer): X________________________________
Parent/Guardian Name (printed)________________________________Date_______________

Physical Exam – ***To be completed by licensed physician***

This exam should be performed within 12 months of arrival at camp. Examination for some other purpose within this period is acceptable. Examination should be focused on determining fitness to engage in strenuous activity.

Allergies: ☐ NKDA

☐ Physical exam within normal limits

☐ Exam notable for the following:

Activity should be restricted as follows:

- o No restriction

Special precautions/ dietary restrictions:

Signature of Physician:___________________________Date:_______________
Address:____
Phone:____________________