WANAKEE HEALTH FORM

Year:

Participant: Last First MI **Birth Date:** MM/DD/YYYY **Age at Camp:**

Health histories must be completed and submitted annually by parents/guardians. These should be completed online in our registration portal. **NH law requires that each camper has a physical within two years of coming to camp.** Please bring a signed physical verification and record of immunizations with you when you come to camp. Complete all sections of this form, which is REQUIRED at check-in and MUST BE COMPLETED for all adult and child campers, volunteers, and staff attending camp events.

CONTACT INFORMATION

Custodial Parent/Guardian Name (for child participant):

Home Phone:[ ] Work Phone:[ ] Mobile:[ ]

Address:
Street City/State Zip

Other Legal Parent/Guardian Name (for child participant):

Home Phone:[ ] Work Phone:[ ] Mobile:[ ]

Address:
Street City/State Zip

Emergency Contact (someone other than listed above who can contact parent/guardian):

Name: Relationship:

Home Phone:[ ] Work Phone:[ ] Mobile:[ ]

INSURANCE

Participants will be covered under their own health insurance policy while at camp.

Is participant covered by a health insurance plan? ◯ Yes ◯ No

If yes, Name of Insurance Carrier:

Policy Number: Policy Holder:

DOB of Policy Holder: Relationship to Participant:

Mailing Address/Phone of Carrier:

ALLERGIES

List all known allergies, type of reaction and required treatment:

- ◯ Poison Ivy/Oak:
- ◯ Insect Bites/Stings:
- ◯ Foods:
- ◯ Medications:
- ◯ Other Allergies:

VACCINATIONS

Attach current documentation of the following Vaccinations/Immunizations:

- **Measles, Mumps, Reubella** (MMR–Dose 2 required grades 7–12)
- **Hepatitis B** (if born on/since 01/01/1993)
- **Varicella** (Chicken Pox/not mandatory)
- **Polio** (3 doses or more, last does after 4th birthday)
- **DTaP** (4 doses or more, 4th dose between 4th and 7th birthday) **Adult Booster DT** within past 10 years

CONDITIONS & RESTRICTIONS

Indicate if participant has any of the following physical, dietary, or emotional conditions. What is the best way to handle these conditions and are there any that would restrict activity while at camp?

◯ Asthma	◯ Chronic illness	◯ Fainting	◯ Sleep walking	◯ Seizures
◯ Back pain	◯ Dental ware	◯ Hearing impaired	◯ Menstrual issues	◯ Vision impaired
◯ Bed wetting	◯ Diabetic	◯ Heart condition	◯ Stomach problems	◯ Nightmares
◯ Developmental delay	◯ Emotional illness	◯ Behavior issues	◯ Learning disability	
◯ High blood pressure	◯ ADD/ADHD	◯ Other (please list):		

Explain any marked conditions/restrictions:

Participant: Last First MI **Birth Date:** MM/DD/YYYY **Age at Camp:**

Recent Medical Treatment or Illness (please describe):

Has the participant had recent exposure to a contagious disease or illness?

PRESCRIBED & OTC MEDICATIONS

The Camp Health Officer shall administer any "as needed" medications from the infirmary/clinic including but not limited to the following: Acetaminophen (Tylenol), Ibuprofen (Motrin), Diphenydramine (Benadryl), Sudafed, PeptoBismol, Calamine Lotion, Tums, Hydrocortisone Cream, Antibiotic Ointment, Eye Drops. Please indicate if there are any of the above you do not want the participant to receive.

MEDICATIONS (prescribed and over-the-counter) BROUGHT FROM HOME TO BE TAKEN AT CAMP:

Medication	Dosage	Time	Used For
Medication	Dosage	Time	Used For
Medication	Dosage	Time	Used For
Medication	Dosage	Time	Used For
Medication	Dosage	Time	Used For

Regular medications that will NOT be taken at camp:

IMPORTANT NOTE: Camp is similar to school environment. Many participants are more successful taking medications normally taken during school. **ALL MEDICATIONS** (prescriptions, over-the-counter, vitamins, aspirin, etc.) **MUST BE IN ORIGINAL CONTAINERS and given to the Camp Health Officer at Check-in.** All unused medications shall be returned to you. This pertains to all adult and child campers, volunteers, & staff.

AUTHORIZATION

Authorization for Treatment:

This health information/history is correct and complete to the best of my knowledge. The participant has no physical or mental disabilities that would impair their participation except as noted. All medications (prescribed & over-the-counter) shall be given to the Camp Health Officer upon arrival at camp. I authorize trained staff to provide first aid, the Camp Health Officer to assess injuries and illnesses, and to administer certain medications as indicated.

A camp doctor is available to the Camp Health Officer for consultation or medical assessment and/or treatment. In the event of serious illness or injury, I authorize the physician and/or hospital to undertake such treatment of and perform such services (including surgical) for the participant as are reasonably indicated by the circumstances. I give the camp permission to arrange necessary related transportation for medical treatment for me/my child.

The health information provided is for the purpose of safe camp experience and to meet the health care needs of the participant. The information shall be keep private and confidential, shared only as absolutely needed for the health and safety of the participant or with other medical providers in the event of an emergency.

Signature of Parent/Guardian: Date:

HCP RECOMMENDATIONS

Health Care Provider's Recommendations (must be completed and signed by medical personnel):

Name of HCP (please print): Title:

Address: Phone: [ ]

Date of last health exam: **(NOTE: NH law REQUIRES physical exam within 2 YEARS of camp arrival.)**

Health History: I concur with the listed **medications, immunizations, and health history** on both sides of this form:

◯ Yes ◯ No This person is under the care of a HCP for the following additional conditions and listed medications/treatments:

Treatment to be continued at camp:

Description of any limitation or restriction on camp activities:

Additional information for camp nurse and staff to be aware of:

Immunizations: Immunizations are all current: ◯ Yes ◯ No PLEASE ATTACH DOCUMENTATION OF IMMUNIZATIONS

Camp Participation: In my opinion, the above participant: ◯ is ◯ is not able to participate in an active camp program.

Signature of Licensed Health Care Provider: Date: