

HEALTH FORM 2010

For children and adults attending

WINONA CAMPS FOR BOYS

35 Winona Road, Bridgton, ME 04009-3407

Tel: 207-647-3721 Fax: 207-647-2750 Email: information@winonacamps.com

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care.

Name: _____ Birthdate: _____ Male/Female
(Last) (First) (M.I.) (Nickname) (Month/Day/Year) (Circle one)

Address: _____
(Street) (Town) (State/Country) (Zip code)

Primary Parent/Guardian Name(s): _____

Primary Parent/Guardian telephone w/area code:

(h) _____ (c) _____ (w) _____

Secondary Parent/Guardian name: _____

(h) _____ (c) _____ (w) _____

Name of emergency contact other than parent/guardian: _____

(h) _____ (c) _____ (w) _____

Siblings attending Winona this year: _____

Email for correspondence from Health Center: _____

****SIGNATURE REQUIRED BELOW****

This form is correct and complete to my best knowledge. The person herein described has permission to engage in all camp activities except as noted below. I hereby give permission to Winona Camps to provide routine healthcare, administer prescribed medications and seek emergency medical treatment including ordering x-rays or tests. I agree to the release of records necessary for treatment, referral, billing or insurance purposes. I give permission to the camp to arrange necessary related transportation for the person. In the event I can not be reached in an emergency, I hereby give permission to the physician selected by Winona Camps to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp. [If you wish to **refuse treatment**, please contact the Winona office for a refusal form.]

***Signature of parent/guardian or adult staff (18 or over)**

(Signature) (Date)

Health Information to be provided by parent(s)/guardian(s) or adult staff:

The intent of this information is to provide Winona healthcare personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any change to the information on this form should be provided in writing to Winona Camps health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of any health needs.

1. ALLERGIES (if YES, please list) _____

Medication Allergy: YES / NO _____

Food Allergy: YES / NO _____

Other Allergy: YES / NO _____

2. ASTHMA: YES / NO _____

Inhaler: YES / NO _____

3. EPI PEN or ANA KIT: YES / NO - If YES, please list circumstances, describe reaction & management: _____

4. CONDITIONS OR RESTRICTIONS affecting your child's activity: _____

5. Please list ALL medications (including prescription and non-prescription) taken. Bring enough medication to last the entire time at camp. Prescription drugs must be kept in the original packaging/bottle that identifies the prescribing physician.

**The Health Center will ONLY administer medications sent in original containers, with instructions in English.*

	Medication name	Dose	Schedule	Diagnosis/Reason for taking medication
a.	_____	_____	_____	_____
b.	_____	_____	_____	_____
c.	_____	_____	_____	_____
d.	_____	_____	_____	_____

6. Note any medications used during the school year that will NOT be taken while at camp:

7. Dietary Restrictions:

8. Immunization Information:

A copy of immunization record must be attached to this form

Date of last tetanus shot: _____ Date of last H1N1 vaccine(s): _____

9. Please provide information regarding your child's physical and emotional history that Winona should be aware of - attach an additional sheet if necessary: _____

10. DOCTOR / INSURANCE INFORMATION

Attach a photocopy of the face and back of insurance card.

Name of Carrier: _____ Group # _____ ID# _____

Carrier Address: _____

Name of Insured: _____

Family Physician's Name: _____ Phone: _____

Dentist/Orthodontist's Name: _____ Phone: _____

TO BE COMPLETED BY LICENSED MEDICAL PERSONNEL

**Exam must be completed within 24 months of camp attendance.*

Date of exam: _____ B/P _____ Pulse _____ Weight _____ Height _____

Significant health history: _____

The camper is under the care of a physician for the following conditions: _____

Restrictions or recommendations & treatments to be continued at camp: _____

In my opinion, this camper _____ is _____ is not able to participate in an active camp program.

Signature of licensed medical personnel

(Date)

Address: _____

(Street)

(Town)

(State/Country)

(Zip code)

Phone: _____