



**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)*

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Asthma                        | <input type="checkbox"/> Diabetes                               | <input type="checkbox"/> Seizure disorder      | <input type="checkbox"/> Heart disease    |
| <input type="checkbox"/> Bleeding disorder             | <input type="checkbox"/> Hypertension                           | <input type="checkbox"/> Renal disease         | <input type="checkbox"/> Immunodeficiency |
| <input type="checkbox"/> Chickenpox                    | <input type="checkbox"/> Tuberculosis                           | <input type="checkbox"/> Visual problems       | <input type="checkbox"/> Hearing deficits |
| <input type="checkbox"/> Musculoskeletal abnormalities | <input type="checkbox"/> Liver disease                          | <input type="checkbox"/> Absence of eye/kidney | <input type="checkbox"/> Other            |
| <input type="checkbox"/> Recent hospitalization        | <input type="checkbox"/> Infectious illness within past 3 weeks |  |   |

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

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

DTaP	_____	_____	_____	_____	Td	_____
Polio	_____	_____	_____	_____		
MMR	_____	_____	_____	_____		
Hib	_____	_____	_____	_____		
Varicella	_____	_____	_____	_____		
Hep B	_____	_____	_____	_____		
ppD	_____	Result:	_____	_____		
Other:						

**Laboratory Testing:**

	<u>Date</u>	<u>Result</u>
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.*

Physical exam within normal limits

Exam notable for the following:

**Allergies:** NKDA

Activity should be restricted as follows:

- No restriction

Special precautions/ dietary restrictions:

Signature of Physician: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_