HEALTH FORM 2018

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

Name: _____Birthdate:___/___/____ Male/Female
(Last) (First) (M.I.) (Nickname) (Month/Day/Year) (Circle one)

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

One parent/guardian Email address for correspondence from Health Center:_____

Primary Parent/Guardian Name(s):_____

Primary Parent/Guardian telephone w/area code: _____ _____ _____
(home) (cell) (work)

Secondary Parent/Guardian name:_____

Secondary Parent/Guardian telephone w/area code:_____ _____ _____
(home) (cell) (work)

Name and phone number of emergency contact other than parent/guardian: _____

Siblings attending Winona this year:_____

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.

***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 healthcare personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of any health needs.

1. ALLERGIES: **YES / NO** (if **YES**, list) _____

Medication Allergy: **YES / NO** (if **YES**, list) _____

Food Allergy: **YES / NO** (if **YES**, list) _____

Other Allergy: **YES / NO** (if **YES**, list) _____

2. ASTHMA: **YES / NO** (if **YES**, list known trigger, frequency & treatment) _____

_____

Inhaler: (if **YES, indicate typical use in a week or month) _____

3. EPI PEN or AUTO-INJECTOR: **YES / NO** (if **YES**, list circumstances, describe reaction & management) _____

_____

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

5. List ALL medications (including prescription and non-prescription) taken. Bring enough medication to last the entire time at camp. Staff, age 18 and older: for privacy reasons if you opt not to list medications here, you are required to discuss medication details with a Winona healthcare provider.

The Health Center will ONLY administer medications sent in original containers, with instructions in English. We do not accept homeopathic treatments.

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

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

7. History of significant concussion? **YES / NO** (if **YES**, list date & treatment)_____

8. Dietary Restrictions: _____

9. **Immunization Information**: ☐ **I have enclosed a copy of the immunization record.**

   a. **YES / NO** Current with the recommended CDC immunization schedule

   b. Date of last tetanus shot: __/___/__

Physicians' office requires a photocopy of the front and back of insurance card

☐ **I have enclosed a copy of the front and back of the insurance card (for campers & staff living in the U.S.).**
☐ **(for International campers) I have enclosed a copy of my *TRAVEL HEALTH INSURANCE* policy.**
☐ **Guarantor's date of birth __/__/____ (Required by local physician's office and hospital.)**

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TO BE COMPLETED BY LICENSED MEDICAL PERSONNEL

Winona recommends your son have a "well child check-up"/physical within 12 months of the start of camp.
We require your son to have a" well child check-up"/physical within 24 months of the start of camp.

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: _____

_____

YES / NO This child is current, based on age, with the recommended CDC Immunization schedule.

If no, explain: _____

Signature of licensed medical personnel: _____(Date)____/____/____

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

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

Phone: _____ Fax: _____