HEALTH FORM 2019

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)

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

1st Parent/Guardian Name(s): _____

Best telephone number(s)for parent/guardian: _____

Best Email for Parent/Guardian: _____

2nd Parent/Guardian Name(s): _____

Best telephone number(s) for parent/guardian: _____

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

Siblings attending Winona/Wyonegonic 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 (Food, Medication, other): Yes/No (If yes, please list) _____
   _____
2. Epi Pen or Auto-injector: Yes/No (if yes, list last use, circumstances, & reaction)_____
   _____
3. Asthma: Yes/No (if yes, list known triggers, frequency, treatment and if applicable use/frequency of inhaler)
   _____
   _____
4. Any conditions or restriction affecting your child's activity: _____
   _____
5. Dietary Restrictions: _____
   _____

6. History of significant concussion? Yes/No (if yes, list date and treatment)_____
_____
7. Treated for and/or diagnosed with Lyme disease? Yes/No (if yes, date and treatment) _____
_____
8. Any major injuries, significant illness or surgeries? Yes/No (if yes, please list date and brief description)
_____
9. Medications:
a. List ALL medications that will be brought to camp, both prescription and over-the-counter. Make sure to bring enough medications to last the session. The health center can only administer medication sent in original containers with clear instructions in English. Winona Health Center has a supply most OTC medications for acute needs.

Medication	Dose	Schedule (AM, PM, etc.)	Length of time on medication	Diagnosis/reason for taking medication

b. Note any medications taken during the school year which will NOT be taken at camp. Please include anticipated date of last dose before camp:_____
_____
10. Immunization information
a. Current with CDC recommended immunization for age? Yes/No (if no, please explain): _____
b. Include full copy of most recent immunization record
11. Insurance information
a. Include front and back copy of card (US) or international travel policy
b. Name_____ date of birth _____
of guarantor on policy (required by local physician and hospitals)

TO BE COMPLETED BY A 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: _____ BP: _____ 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: _____

Printed name: _____

Address: _____

Phone: _____ Fax: _____