# CAMP WASTAHI MEDICAL FORM

***DUE ON OR BEFORE JULY 1, 2017***

## INSTRUCTIONS FOR COMPLETING THIS FORM:

A 2017 Medical Form is required for each participant of Camp Wastahi. This form must be completed in full and **submitted no later than July 1, 2017 .** Camp Wastahi requires this medical form to be filled out and submitted EACH YEAR. As a requirement of this form, a **current physical** must have been completed within 24 months (2 years) of the camp week.

**A completed form includes**:

- Completed "*Participant Portion*" (pages 2-6)
- Completed "*Physician Portion*" (pages 7-8), signed/stamped by the participant's physician. This is required EACH YEAR even if the participants physical examination is still current. *
- A photocopy of both sides of the participants Medical Insurance Card (if applicable).*
- A copy of participants Vaccination/Immunization Record.* All Vaccinations must be up to date.

* *Camp Wastahi is not responsible for retaining and resubmitting any forms. Any re-use of forms must be approved by Camp Wastahi Directors and submitted along with the 2016 "Participant Portion".*

**PLEASE NOTE: Any participants *without* a completed medical form are not permitted on campus. In this instance, all refundable payments will be refunded by August 30, 2017.**

***-- KEEP A COPY OF THE COMPLETED FORM FOR YOUR RECORDS --***

# PARTICIPANT PORTION

*This portion must be filled out by the Parent/Guardian of the Participant (if under the age of 18) to the best of their knowledge for every camp year. If there are any additional health or nutrition concerns please attach an additional page.*

Camper Name: ____________ Age: ______

(For Camp Use) Cabin Group ____________

## GENERAL INFORMATION

Camper Name ________________________________ Camp Name: __________________

Date of birth: ____/____/______ Age at camp: _______ Male ☐ Female ☐

Address: ____________________________________________ City: __________________

State: ________ Zip code: __________________ Phone No. (_____)__________________

Health insurance company: ______________________________ Policy No.:____________

If you have no health insurance please check this box ☐

Primary Physician __________________________ Phone No. (_____)_________________

## EMERGENCY CONTACTS (In case of injury or illness):

**Contact #1: (Parent/guardian with legal custody to be contacted in case of illness or injury)**

Name __________________________________ Relationship ______________________

Address______________________________________________________________________

Home (_____) _____________ Work (_____) _____________ Cell (_____) _____________

**Contact #2: (Parent/guardian with legal custody to be contacted in case of illness or injury)**

Name __________________________________ Relationship ______________________

Address:_____________________________________________________________________

Home (_____) ______________ Work (_____) ______________ Cell (_____) _____________

**Contact #3: (Additional contact in event parent(s)/guardian(s) can not be reached)**

Name __________________________________ Relationship ______________________

Address:_____________________________________________________________________

Home (_____) ______________ Work (_____) ______________ Cell (_____) _____________

## ALLERGY INFORMATION:

☐ The participant has **NO KNOWN ALLERGIES**

☐ The participant has an **ANAPHYLACTIC ALLERGY** to:

☐ Food ☐ Medicine ☐ The Environment ☐ Other

*Detail the specific allergen, reaction, and medication/action required if exposed. (Attach additional page if needed)*

Allergen Reaction Medication/Action

☐ The participant has a **NON-ANAPHYLACTIC ALLERGY** to:

☐ Food ☐ Medicine ☐ The Environment ☐ Other

*Detail the specific allergen, reaction, and medication/action required if exposed. (Attach additional page if needed)*

Allergen Reaction Medication/Action

☐ The participant has an **MILD REACTION** to:

☐ Food ☐ Medicine ☐ The Environment ☐ Other

*Detail the specific foods, reaction, and medication/action required if exposed. (Attach additional page if needed)*

Cause Reaction Medication/Action

## NUTRITIONAL INFORMATION:

Camp Wastahi prides itself on the quality of its food. Vegetarian options are available for every meal. *For children with other special dietary restrictions (such as gluten free or lactose free products), please send substitute foods (to cover 6 days) to camp for your child labeled with the campers name or select "gluten free diet" on the Registration Form for an additional fee.*

**DIETARY RESTRICTIONS:** (check all boxes that apply)

☐ This person has **NO RESTRICTIONS** ☐ This person has **DIETARY ALLERGIES** (as outlined above)

☐ Does not eat red meat ☐ Does not eat pork ☐ Does not eat eggs

☐ Does not eat poultry ☐ Does not eat seafood ☐ Does not eat dairy products

☐ Does not eat nuts ☐ Does not eat gluten*

☐ Does not eat other (please indicate)________________________________

☐ Is a **PARTICULARLY PICKY EATER** (Please detail foods the camper *WILL ONLY* or *WILL NOT* eat)

**Campers that do not eat gluten have the option of paying an addition $60 to eat gluten free foods, supplied by camp, similar to the camp meals prepared. This option is offered in the Registration Form on the "Payment Worksheet".*

Camper Name:____________ Age:______

(For Camp Use) Cabin Group_________

Camper Name: ______________________ Age: ____

(For Camp Use) Cabin Group ____________

## MEDICAL INFORMATION:

For the health and safety of your camper, Camp Wastahi has a Health Care Specialist (LVN or RN) on campus at all times and a Physician on call for the entire session.

**IMMUNIZATIONS:** (choose one box) ***Please attach their immunization record to this form.***

*The following vaccines/immunizations are recommended by the camp:*

**Tetanus* Polio Measles Mumps Chicken Pox Pertussis Hepatitis A Hepatitis B Rubella**

**Tetanus immunization must have been received within the last 10 years.*

☐ This participant's immunizations are current. *See attached Vaccination/Immunization Record*
☐ This participant is EXEMPTED from immunizations*

*If participant is not fully immunized, please sign the following statement:
"I understand and accept the risks to my child from not being fully immunized."

Custodial Parent/Guardian Signature: ______________________________ Date: ____________

**HEALTH HISTORY:** Check "Y" of "N" for each statement. Explain "yes" answers below

Has/does the participant

1. Ever been hospitalized? ☐**Y** ☐**N**
2. Ever had surgery? ☐**Y** ☐**N**
3. Have recurrent/chronic illness? ☐**Y** ☐**N**
4. Had a recent infectious disease? ☐**Y** ☐**N**
5. Had a recent injury? ☐**Y** ☐**N**
6. Have diabetes? ☐**Y** ☐**N**
7. Had/has seizures? ☐**Y** ☐**N**
8. Prone to headaches? ☐**Y** ☐**N**
9. Had/has fainting or dizziness? ☐**Y** ☐**N**
10. Have any skin problems? ☐**Y** ☐**N**
11. Have a history of bedwetting? ☐**Y** ☐**N**
12. Had/has back or joint problems? ☐**Y** ☐**N**
13. Had asthma/wheezing/shortness of breath? ☐**Y** ☐**N**
14. Wears glasses, contacts, or protective eyewear? ☐**Y** ☐**N**
15. Passed out and/or had chest pain during exercise? ☐**Y** ☐**N**
16. Had mononucleosis ("mono") within the last 12 months? ☐**Y** ☐**N**
17. If female, have problems with menstruation? ☐**Y** ☐**N**
18. Have sleep issues (problems falling asleep, insomnia, sleepwalking, apnea, etc.)? ☐**Y** ☐**N**
19. Have problems with diarrhea/constipation? ☐**Y** ☐**N**
20. Traveled outside the country in the past 9 months? ☐**Y** ☐**N**

*In the space below explain "Yes" answers, noting the number of the correlating question. For travel outside the country, name countries visited and dates of travel.*

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**MENTAL, EMOTIONAL, and SOCIAL HEALTH:**
Check “Y” of “N” for each statement. Explain “yes” answers below, noting the number of the correlating question.

Has the participant
1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? ☐**Y** ☐**N**
2. Ever been treated for emotional/behavioral difficulties or eating disorder? ☐**Y** ☐**N**
3. During the last 12 months, seen a professional to address mental/emotional health concerns? ☐**Y** ☐**N**
4. Had a significant life event that continues to affect the participant’s life? (History of abuse, death of loved one, family change, adoption, foster care, new sibling, survived a disaster, etc.) ☐**Y** ☐**N**

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**What have we forgotten to ask?:**
Please provide in space below any additional information about the camper’s health that you think important or that may affect the camper’s ability to fully participate in the camp program. Or anything you would like to us know about your camper, including any special needs/concerns. Attach additional information if needed.

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

## MEDICATION

**NON-PRESCRIPTION MEDICATIONS CONSENT:** (check all boxes that apply)
Camp Wastahi provides the listed medication below. Under the supervision of the Health Care Specialist, please indicate which medications may be dispensed to your child:

☐ YES ☐ NO Acetominophen (Tylenol™)
☐ YES ☐ NO Ibuprophen (Advil/Motrin)
☐ YES ☐ NO Tums: For upset stomach
☐ YES ☐ NO Cough drops: For sore throat
☐ YES ☐ NO Sore throat spray
☐ YES ☐ NO Calamine lotion
☐ YES ☐ NO Antibiotic cream (Neosporin)
☐ YES ☐ NO Aloe
☐ YES ☐ NO Guaifenesin/Dextromethorphan, Generic cough syrup
☐ YES ☐ NO Phenylephrine decongestant (Sudafed PE™)
☐ YES ☐ NO Pseupoephederine decongestant (Sudafed™)
☐ YES ☐ NO Diphenhydramine Antihistamine/ allergy medicine (Benadryl™)
☐ YES ☐ NO Laxatives for constipation (Ex-Lax)
☐ YES ☐ NO Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)

☐ OTHER (Please Specify) ____________________________________________
☐ **NONE OF THE ABOVE** — if this box is checked, **NO** non-prescription medications will be administered

*Special instructions for administering any of the above medications:*

______________________________________________________________________________
______________________________________________________________________________

Camper Name: ______________________ Age: ______

(For Camp Use) Cabin Group ______________

## PRESCRIPTION and REQUIRED OTC MEDICATIONS

List ***ALL*** medications currently used below. (*If additional space needed, please photocopy this part of the health form.*) Inhalers and EpiPen information must be included, even if they are for occasional or emergency use only. Vitamins and any OTC medications must also be included.

***Notice about medications:*** *It is essential to send the sufficient quantity of medications to camp (for seven full days). Prescribed medications must be in their original containers and clearly labeled with the camper's name, dosage, frequency and the name of the prescribing physician. Make sure all medications sent to camp are NOT expired. OTC medications must also be in their original containers with dosage instructions and frequency of administration, especially as to whether medication is taken regularly or on an 'as need only' basis. Camp medical personnel are not authorized to dispense any medication sent to camp that is not detailed on this form or without specific instruction.*

*****Your child SHOULD NOT STOP taking any maintenance medication while at camp*****

## LIST OF MEDICATIONS

☐ This camper **will not** take any daily medications while attending Camp Wastahi

☐ This camper **will** take the following daily medication(s) while attending Camp Wastahi:

*** attach additional pages as needed***

| Medication | Date Started | Reason for taking | When it is given | Dosage | How it is given |
|---|---|---|---|---|---|
| | | | ☐ Breakfast<br>☐ Lunch<br>☐ Dinner<br>☐ Bedtime<br>☐ Other: ____________ | | |
| | | | ☐ Breakfast<br>☐ Lunch<br>☐ Dinner<br>☐ Bedtime<br>☐ Other: ____________ | | |
| | | | ☐ Breakfast<br>☐ Lunch<br>☐ Dinner<br>☐ Bedtime<br>☐ Other: ____________ | | |

*This form is accurate to the best of my knowledge, and I am responsible for any inaccuracies.*

*I approve the sharing of the information on this form with Camp Wastahi volunteers and professionals who need to know of medical situations that might require special consideration for the safe conduct of camp activities. In case of an emergency involving the Camper, I understand that every effort will be made to contact the individuals listed as the Guardians or Emergency Contact. In the event that none of these persons can be reached, permission is hereby given to the medical provider selected by the adult leader in charge to secure treatment, including, but not limited to, hospitalization, anesthesia, surgery, or injections of medication for the Camper. Medical providers are authorized to disclose to the adult in charge examination findings, test results, and treatment provided for purposes of medical evaluation of the Camper, follow-up and communication with the Camper's Guardians, and/or determination of the Camper's ability to continue in the program activities. I agree to be financially responsible for all treatment. I further authorize Camp Wastahi staff to provide routine non-emergency medical care.*

X________________________________ X________________________________ ______________

*Parent/guardian's name (please print)* *Parent/guardian's signature* *Date*

X________________________________ X________________________________ ______________

*Parent/guardian's name (please print)* *Parent/guardian's signature* *Date*

Camper Name: ______________________ Age: ______

(For Camp Use) Cabin Group ______________

# PHYSICIAN PORTION

***THIS PORTION MUST BE COMPLETED, SIGNED/STAMPED AND DATED BY A MEDICAL PROFESSIONAL.*** "Medical Professional's" recognized by Camp Wastahi to perform this exam include: Physicians (MD, DO), Nurse Practitioners, and Physician's Assistants.

Provider: Please fill out this form with most current physical exam findings. The participant must have had a physical within 24 months of July 2017. *If there have been changes in health since previous exam, a new physical is required*. Provider may use own form, if available. Please attach additional pages as needed.

Camper Name: ____________ Age: ______

(For Camp Use) Cabin

## PHYSICAL EXAMINATION:

Camper Name: ______________________________ Age at camp: __________
Date of Physical Exam: ____/____/________ Height____________ Weight_____________
Blood Pressure ______________ Pulse____________

**ALLERGIES:**

☐ **ANAPHYLACTIC** ☐ To the environment (Insect stings, hay fever, etc. – list)
☐ To foods (list) ☐ Other allergies (list) ☐ **No known allergies**

Detail reactions and antidote:

______________________________
______________________________
______________________________
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______________________________

**DIET AND NUTRITION:**

☐ Eats a regular diet ☐ Has a medically prescribed meal plan or dietary restrictions (describe below)

______________________________
______________________________
______________________________
______________________________
______________________________

**MEDICATION/TREATMENTS:**

☐ No daily medications
☐ Will take the following medication(s) while at camp (name, dose, frequency – describe below)
☐ Other treatments/therapies to be continued at camp: (describe below)

______________________________
______________________________
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______________________________

## ADDITIONAL COMMENTS/CONCERNS:

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
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*I certify I have reviewed the health history, examined this person, and approve this individual's participation in:*

**Hiking**: ☐ Yes ☐ No ☐ *With Restrictions **Competitive Activities**: ☐ Yes ☐ No ☐ *With Restrictions

**Sports**: ☐ Yes ☐ No ☐ *With Restrictions **Sleeping Outdoors**: ☐ Yes ☐ No ☐ *With Restrictions

**Swimming/Water Activities**: ☐ Yes ☐ No ☐ *With Restrictions

***To Health Care Provider:*** **Restricted approval includes, but is not limited to:*

- ☐ Uncontrolled heart disease, asthma, or hypertension.
- ☐ Uncontrolled psychiatric disorders.
- ☐ Poorly controlled diabetes.
- ☐ Newly diagnosed seizure events (within 6 months)
- ☐ Other: ________________________________ (please detail below)

***Specific Restrictions and Instructions:** (if none, write N/A)

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Provider Name (print) ________________________________________ Date ______________

Provider Signature ________________________________ Office phone (_____)______________

Address ________________________________________________________________________

Camper Name: ______________________ Age: ______

(For Camp Use) Cabin