



## CAMP WASTAHI MEDICAL FORM

**DUE ON OR BEFORE JULY 1, 2018**

### **CHECK LIST & INSTRUCTIONS FOR COMPLETING THIS FORM:**

This Medical Form is required EACH YEAR for every participant of Camp Wastahi. As a requirement of this form, a **current physical** must have been completed within 24 months (2 years) of the camp week.

#### **COMPLETED FORM CHECK LIST:**

- Participant Portion (pages 2-6)**
  - Completed and signed by guardian
  - **No resubmittal of previous years accepted.**
- Physician Portion (pages 7-8)**
  - Completed and signed/stamped by the participant's physician.
  - Resubmittal of this portion from 2017 attendance is accepted ONLY IF physical examination is still current. \*
- Medical Insurance Card:**
  - Photocopy or PDF of both sides of participants (if applicable).
- Participant's Vaccination/Immunization Record**
  - All Vaccinations must be up to date.
  - Photocopy or PDF

**\* It is Applicant's responsibility to provide forms for resubmittal.** Camp Wastahi is not responsible for retaining and resubmitting any forms. Any re-use of forms must be approved by Camp Wastahi Directors.

**NOTE:** Any participants without a completed medical file by JULY 21, 2018 are not permitted on campus. In this instance, all refundable payments will be refunded by August 30, 2018.

**-- 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(s).*

### 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 (\_\_\_\_) \_\_\_\_\_

Camper Name: \_\_\_\_\_  
Age: \_\_\_\_\_

(For Camp Use) Cabin Group \_\_\_\_\_

**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", page 2.*

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) Attach current immunization record to this form.

The following 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.*

The signature below confirms that:

This participant's immunizations are current. See attached Vaccination/Immunization Record

This participant is **EXEMPT** from immunizations:

**"I understand and accept all risks to my child as a result of 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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Camper Name: \_\_\_\_\_ Age: \_\_\_\_\_

(For Camp Use) Cabin Group \_\_\_\_\_

**MENTAL, EMOTIONAL, and SOCIAL HEALTH:**

Check “Y” or “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

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**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.

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**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:

- |   |  |
|---|--|
| <input type="checkbox"/> YES <input type="checkbox"/> NO Acetaminophen (Tylenol™)   | <input type="checkbox"/> YES <input type="checkbox"/> NO Phenylephrine decongestant (Sudafed PE™)                      |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Ibuprophen (Advil/Motrin)  | <input type="checkbox"/> YES <input type="checkbox"/> NO Pseudoephedrine decongestant (Sudafed™)                       |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Tums: For upset stomach  | <input type="checkbox"/> YES <input type="checkbox"/> NO Diphenhydramine Antihistamine/ allergy medicine (Benadryl™)   |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Cough drops: For sore throat   | <input type="checkbox"/> YES <input type="checkbox"/> NO Laxatives for constipation (Ex-Lax)                           |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Sore throat spray  | <input type="checkbox"/> YES <input type="checkbox"/> NO Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol) |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Calamine lotion  |  |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Antibiotic cream (Neosporin)   |  |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Aloe   |  |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Guaifenesin/Dextromethorphan, Generic cough syrup                              |  |
| <input type="checkbox"/> OTHER (Please Specify) _____   |  |
| <input type="checkbox"/> <b>NONE OF THE ABOVE</b> — if this box is checked, <b>NO</b> non-prescription medications will be administered |  |

Special instructions for administering any of the above medications:

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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 all OTC medications accompanying camper to camp 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 needed"(PRN) basis. Camp medical personnel are not authorized to dispense any medication sent to camp 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
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> 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 \_\_\_\_\_ Date \_\_\_\_\_  
 Parent/guardian's name (please print) Parent/guardian's signature

X \_\_\_\_\_ X \_\_\_\_\_ Date \_\_\_\_\_  
 Parent/guardian's name (please print) Parent/guardian's signature

Camper Name: \_\_\_\_\_  
 Age: \_\_\_\_\_  
 (For Camp Use) Cabin Group \_\_\_\_\_

## PHYSICIAN PORTION

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

**To the Provider:** Please fill out this form with most current physical exam findings. The participant must have had a physical within 24 months of July 2018. *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.

### PHYSICAL EXAMINATION:

Camper Name: \_\_\_\_\_ Age at camp: \_\_\_\_\_  
Date of Physical Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_

**ALLERGIES: check and detail all that apply**

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

Detail reactions and antidote:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### **DIET AND NUTRITION:**

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### **MEDICATION/TREATMENTS: check and detail all that apply**

- 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)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Camper Name: \_\_\_\_\_

Age: \_\_\_\_\_

(For Camp Use) Cabin \_\_\_\_\_

**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)

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Provider Name (print) \_\_\_\_\_ Date \_\_\_\_\_

Provider Signature \_\_\_\_\_ Office phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

Camper Name: \_\_\_\_\_ Age: \_\_\_\_\_

(For Camp Use) Cabin \_\_\_\_\_