

Wooden Acres Adventure Programs

CAMPER MEDICAL REPORT FORM - 2010

This side to be completed by parent or guardian. A medical examination is required to complete side two. If your child has had an exam since the fall of 2009, a new one is not required. Your doctor may complete this form using the most recent medical information.

Camper's Name _____ Grade as of Sept. '10 _____ Sex _____ Birth date _____

Home Address _____ City _____ State _____ Zip _____

Child's Home Phone _____ Parents/Guardians _____

Mother's Home Phone _____ Business Phone _____ Cell _____

Father's Home Phone _____ Business Phone _____ Cell _____

Health Insurance Company _____ Policy # _____

Name of Doctor _____ Phone # _____

Name of Dentist _____ Phone# _____

Please check off which of the following camper HAS HAD. Double check if camper had any trouble within the last year. Circle those that might trouble him/her this summer:

- | | | | |
|---|--|--------------------------------------|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Strep Throat | <input type="checkbox"/> Sleep walk | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Heart Trouble |
| <input type="checkbox"/> Frequent Fainting | <input type="checkbox"/> Ear Trouble | <input type="checkbox"/> Eye Trouble | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Urinary Infections | <input type="checkbox"/> Orthopedic problems | | |

Additional medical/physical/psychological/emotional/allergy information: _____

My child does not have any infectious diseases or physical limitations other than listed above. _____
Initial here

HEALTH AND SAFETY AGREEMENT:

Camp has my permission to provide routine non-surgical medical care. In the event of a medical emergency and I cannot be reached, I hereby give permission to the physician selected by the camp director or his agent to hospitalize, secure treatment for, and to order injections, anesthesia, or surgery for my child as named herein. I also understand that I am responsible for the costs incurred on behalf of my child relating to accident or illness when treated outside the camp, although the fullest safety precautions are taken, the camp does not assume responsibility for any accident. I give permission to the camp director or other designated staff member to contact anyone treating my child for emotional reasons. The information obtained from such persons will only be used to provide for the welfare of the child at camp. I have read the PARENT/CAMPER MANUAL and agree to abide by the requirements set forth therein. I understand that my child will not be allowed to take medication from home unless it is ordered by a physician and so noted on this form. I hereby accept the provisions of the Health and Safety Regulations.

PERSONS TO WHOM CHILD MAY BE RELEASED TO, OR CONTACTED IN CASE OF EMERGENCY (ONLY IF PARENTS CANNOT BE REACHED):

NAME _____ RELATIONSHIP _____

HOME PHONE _____ WORK _____ CELL _____

NAME _____ RELATIONSHIP _____

HOME PHONE _____ WORK _____ CELL _____

Signature of parent or guardian

Print Name Legibly

Date

This side to be completed by PHYSICIAN

Please note immunization booster requirements.

Camper's Name _____ Grade as of Sept. '09 _____ Sex _____ Birth date _____

Height _____ Weight _____ Blood Pressure _____

Camper Allergies: ___MEDICATION ___FOOD ___POLLENS, GRASSES, TREES, ETC ___Other

If yes, please explain _____

Has camper had Chicken Pox? ___Yes ___No Date _____ or vaccine _____

Please indicate date of: Last tetanus _____ Last MMR _____

PLEASE ENSURE THAT IMMUNIZATIONS ARE UP TO DATE BEFORE CHILD ATTENDS CAMP.

Has the camper had any surgery? - List with dates _____

Any restrictions or limitations camper must observe? _____

Is, or will camper be taking any medication (including allergy) during the summer? If so, please list:

Medication	Reason
_____	_____
_____	_____
_____	_____

Please indicate whether the child has any emotional, psychological or neurological problems and explain _____

Female Campers: Onset of Menses? ___Yes No ___ Regular? _____ Painful? _____

I have examined the above applicant for entrance to the Wooden Acres Camp and Adventure Teen Travel Programs and find him/her physically qualified to be accepted as a camper and to enter into all camp activities, except with the restrictions stated above.

Signature of examining physician

Please print name legibly

Date

Reverse Side to Be Completed By Parent or Guardian