

Camp Woods Play Health Form 2008

These would be given to medical personnel in case of emergency. Please complete and return by mail or bring with you on the first day of camp (copies at camp if you forget).

Parent/Guardian _____

Home Address _____ Phone () _____

Work Address _____ Phone () _____

Second
Parent _____

Home Address _____ Phone () _____

Work Address _____ Phone () _____

Emergency
Contact _____

Home Address _____ Phone () _____

Name of Family Physician _____
Phone () _____

Name of Dentist/Orthodontist _____
Phone () _____

Is camper covered by family medical/hospital insurance? Yes _____ No _____

If so, indicate Carrier _____ Policy or group # _____

Participation Requests or Limitations

Camper's Name _____ Date of Birth/age _____

Please indicate any pertinent information or requests regarding medical conditions, which may limit or alter participation.

Activity restrictions:

Dietary restrictions:

Medical treatments:

Health History

Immunizations (not required information):

Were immunizations completed prior to entrance to school? Yes No

Month/year of last tetanus immunization (DPT, DT, T)

Yes/No Has Camper Had Any? Yes No Does Camper?

___/___ Chronic or recurrent illness ___ ___ Wear glasses/contacts

___/___ Illness lasting over one week ___ ___ Wear dental braces/appliances

___/___ Hospitalizations ___ ___ Take regular medications

___/___ Surgery ___ ___ Have allergies to medications

___/___ Missing organs ___ ___ Have environmental allergies

___/___ Orthopedic injury/abnormality ___ ___ Have insect allergy

___/___ Problems with heart or blood pressure ___ ___ React strongly to poison ivy

___/___ Chest pain with exercise ___ ___ Have asthma/ recurrent respiratory illness

___/___ Dizziness or fainting with exercise

___/___ Have intolerance to strenuous exercise

___/___ Frequent Headaches

Camper's Name _____ Date of Birth/age _____

___/___ Have a family member who died at less than 40 years of age due to non-accidental causes

___/___ Convulsions

___/___ have a family member of less than 55 whom has had a heart attack

___/___ Concussions or unconsciousness

___/___ Have emotional problems

___/___ Heat exhaustion, heat stroke, or problems with heat

___/___ Have behavioral problems ___ ___ Have bed wetting problem

___/___ Sleepwalking

Use this space to explain any "YES" answers above or to provide any-additional information

This health record is correct as far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted.

EMERGENCY AUTHORIZATION:

I hereby give my permission to the medical personnel selected by the camp director to order x-rays, routine tests, and routine treatment for me/my child, and in the event that I cannot be reached in case of a life-threatening emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injections, anesthesia or surgery for me/my child as named above. This form may be photocopied for use out of camp.

Signature of parent/guardian, _____ Date _____