

WILDERNESS EXPERIENCES UNLIMITED, INC.

MAKE YOUR DOCTOR'S APPOINTMENT EARLY!

If your child needs special medications during his/her stay at Camp, you will need an additional form to allow us to dispense or monitor them. Let us know A.S.A.P. if you will need this form.

Per Board of Health

MUST BE RETURNED NO LATER THAN 14 DAYS PRIOR TO FIRST DAY IN CAMP

CAMP HEALTH EXAMINATION FORM FOR CHILDREN, YOUTH AND ADULTS

Developed by the American Camping Association, Inc

In consultation with: The American Medical Association and the American Academy of Pediatrics

(This side to be completed by Parent or Adult Camper and checked with Physician at time of Examination).

Name: _____ Birth Date _____ Sex _____ Age _____
(Last) (First) (Middle)

Parent/Guardian or Spouse: _____ Tel. _____

Home Address: _____ Zip _____

Business Address: _____ Tel. _____

If not available in Emergency, Please notify:

1. Name _____ Tel. _____

2 Street/Number: _____ City _____ State _____ Zip _____

Health History: Check -giving approximate Dates.

Operations or Serious Injuries (Describe -Give Dates) _____

Chronic or Recurring Illnesses _____

	Allergies	Diseases
Frequent Ear Infections _____	Hay Fever _____	Chicken Pox _____
Heart Defect _____	Ivy Poison etc. _____	Measles _____
Convulsions _____	Insect Stings _____	Measles/German _____
Diabetes _____	Penicillin _____	Mumps _____
Bleeding (Clotting Disorders) _____	Other Drugs _____	Asthma _____
		Other _____

Name of Dentist or Orthodontist _____ Tel. _____

Name of Family Physician _____ Tel. _____

Do you carry family medical/hospital insurance? _____ If yes, indicate:

Carrier _____ Policy or Group # _____

Any specific activities to be encouraged? _____

or restricted? _____

IMPORTANT: Please notify Camp Director promptly if this camper is exposed to any communicable disease during the three (3) weeks prior to scheduled Camp attendance.

Suggestions from Parents: _____

IMPORTANT: Must be completed, signed and dated and returned for Camper Attendance

Parent's Authorization: This health history as accurate so far as I know and the person herein described has

permission to engage in all prescribed activities, except as noted by myself or the examining physician. I hereby give permission to the physician selected by the Camp Director to order x-rays, routine tests and treatment for the health of my child in the event I cannot be reached in an emergency. I also hereby, give my permission to the physician selected by the Camp Director to hospitalize, secure proper treatment for, order injection and/or anesthesia, and or surgery for my child as named above.

Signature: _____ Witness: _____

Date: _____

Campers Name: _____ Date Examined: _____

OFFICE USE ONLY: Date Sent: _____

Date Received: _____

Special Med. Form _____

IMMUNIZATION HISTORY

CAMPERS NAME: _____ **Age:** ____ **Date Examined:** _____ **Year** _____

Required immunizations must be determined locally. Please record the date (Month and year) of basic immunizations and most recent booster doses.

VACCINES _____ **Date:** _____ **Basic Immunization** _____ **Last Booster** _____

Hepatitis B _____

Diphtheria _____

Tetanus _____

_____ or Tetanus/Diphtheria* TD* _____

_____ or Tetanus + Oral Polio (Sabin) TOPV _____

Injectible Polio (Salk) _____

*Give Type (Name) _____

*Measles (Hard Measles), Red Measles. Rubeola) _____

*Rubella (German Measles , Three Day Measles) _____

Tuberculin Test Given – Most recent _____

MEDICAL EXAMINATION – To be completed by Licensed Physician – Summer Campers only,

Examination is for the purpose of determining fitness to engage in strenuous scheduled physical activities.

Examination for some other purpose within this period is acceptable.

CODE: V = Satisfactory X = Not Satisfactory O = Not Examined

Height: _____ Weight : _____ B. P. _____ Hct. Or Hgb Test: _____ Urinalysis: _____

Eyes: _____ Lungs: _____ Allergy (Please specify) _____

Glasses: _____ Abdomen _____

Ears: _____ Hernia: _____

Nose: _____ Extremities _____

Throat: _____ Posture (Spine:) _____

Heart: _____ Skin _____

Genitalia: _____

(For Girls or Women)

Has this person menstruated ? _____ . If not, has she been told about it?

If yes, is her menstrual period normal? _____ Special Considerations? _____

Recommendations and Special Considerations while in camp

Special Diet _____

Swimming/Diving _____

Strenuous Activity _____

Other _____

Current Medications*: _____ **Is parent sending it?** _____

*** Note: The Board of Health requires a special form completed by physician and parent to allow dispensation of any medication by either camper or staff. If this camper requires medication, call 562-7431. We'll send the form! .**

I have examined the person herein described and have reviewed the health history. It is my opinion that this camper is physically able to engage in camp activities except as noted above. Please use space below for additional comments or information if needed.

Signed: _____ **M. D.**

Examining Physician

Telephone: (_____) _____ **Address:** _____

Date: _____

COMMENTS:

W.E.U. SUMMER CAMPS 1981- 2010

Our 30th Summer Season of Making A Difference

Office: 499 Loomis Street, Westfield MA 01085
Store: PO BOX 265. Southwick MA 01077
413-569-1287 Store 413-569-0445 Fax

IMPORTANT NOTICE

To: Parents of Campers requiring the administration of Medications during W.E.U. Summer Camp.

The Health Department regulations require Parental Authorization for the Administration of Medication.

In order to meet the needs of your child, we will need the following signed permission document on file with your current Medical Form.

Date: _____ **Camper's Name:** _____

Medication to be administered: _____

It is very important that you send the medication in its original prescription bottle. Please send just enough medication for your child's stay in camp.

Time: _____ **Dosage:** _____

Reason: _____

Possible Side Effects: _____

Physicians Signature: _____

Until termination by me in writing, you or anyone you authorize, are hereby authorized to administer the above named medication to the above named child.

I understand that the medication will only be given under the following conditions:

1. It is necessary for the medication to be given during camp hours.
2. The medication is in a container labeled with the Physician's name, the name of the medication, the Prescription number, and the directions for its use.
3. The medication will be given according to written directions only.
4. In consideration of your administering this medication to my child as prescribed, I hereby release you, or anyone you authorize to administer the medication, Wilderness Experiences Unlimited, Inc. from any liability whatsoever arising out of the act of administering this medication.

Parent's Signature: _____ **Date:** _____