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. Please see our website or contact us to obtain 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 _____

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

Diptheria

Tetanus

or Tetanus/Diptheria* 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_____

Emotional Needs_____

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, see our website for the special med 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- 2016

35 SUMMERS MAKING A DIFFERENCE

Office: 499 Loomis Street, Westfield MA 01085 413-562-7431
Store: 526 College Highway, 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. Form must be filled out for both prescription and non prescription medications.

The Health Department regulations require both Parental Authorization & Physicians Authorization for the Administration of any 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:_____**