



SUMMER ADVENTURE HEALTH INFORMATION

Camp Session _____

Mail this form to Wildwood at least 2 weeks prior to the opening day of your camp session.

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Any changes to this form should be provided to Wildwood upon participant's arrival at camp. Provide complete information so that we can be aware of your campers needs.

Name _____ Birth date _____ Age at camp _____
First Middle Last

Home Address _____
Street Address City State Zip

Camper Social Security Number _____ Gender: Male Female Height: _____ Weight: _____

Race (circle one) African American Asian American Caucasian Hispanic Other(specify) _____

Family Status(circle one) Married Divorced Separated Single Mother Single Father Other _____

Custodial Parent/Guardian _____ Phone _____

Home Address _____
(if different from above) Street Address City State Zip

Business Address _____ Phone _____
Street Address City State Zip

Second Parent/Guardian or emergency contact

(Circle one)
Address _____ Phone _____
Street Address City State Zip

Business Address _____ Phone _____
Street Address City State Zip

If not available in an emergency, please notify _____

Relationship to camper _____ Phone _____

Address _____
Street Address City State Zip

Insurance Information
Is the participant covered by family medical/hospital insurance? Yes No
If so, indicate carrier or plan name _____ Group # _____

Important - These boxes must be complete for attendance

Parent/Guardian Authorizations: This medical information regarding my child is correct to the best of my knowledge. I have read the Summer Adventure information and give my permission for my child to engage in all learning and recreational activities and trips at Wildwood, except as noted by me on this form. Further, I understand that some trips may be away from Wildwood's main facility. I agree to hold the Wildwood Outdoor Education Center, Inc., its employees, officers, directors and agents, harmless for any accident, injury and/or accident, which may occur in this program.

I also give my permission for the Wildwood Outdoor Education Center to use any photographs or videos take of my child for promotional purposes.

It is my intention that the camp be treated as acting *in loco parentis* if the person herein named is a minor. In the event I cannot be reached in case of an emergency, I hereby consent that the physician selected by the Wildwood Outdoor Education Center may hospitalize and secure proper treatment for my child, including, without limitation, order injection, anesthesia or surgery for my child as named above. I release and hold the Wildwood Outdoor Education Center, Inc., its employees, officers, directors, and agents harmless from any injury or accident to my child which may occur from such activity by the Wildwood Outdoor Education Center, Inc. or such physician.

Signature of parent or guardian _____

Printed Name _____ Date _____

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of Camper _____ Date _____

ALLERGIES List all known. Describe reaction and management of the reaction.

Medication allergies

Food Allergies

Other allergies—include insect stings, hay fever, asthma, animal dander, etc.

Year

Cabin or Group

Name

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

This person **takes NO medications** on a routine basis. OR This person **takes medications** as follows:
Med #1 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____
Med #2 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____
Attach additional pages for more medications.
Identify any medications taken during the school year that participant does/may not take during the summer. _____

RESTRICTIONS (The following restrictions apply to this individual.)

Does not eat: Red meat Pork Dairy Products Poultry Seafood Eggs Other (describe) _____
Explain any restrictions to activity (what cannot be done, what adaptations or limitations are necessary) _____

GENERAL QUESTIONS (Explain "yes" answers below.)

Has/does the Camper:	Yes	No		Yes	No
1. Had any recent injury, illness or infectious disease? ...	<input type="checkbox"/>	<input type="checkbox"/>	15. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	16. Ever had back problems?.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had problems with joints (knees, ankles, etc.)....	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	18. Have an orthodontic appliance being brought to camp?.....	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems (itching, rash, acne).....	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	24. Have problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	25. Have a history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	26. If female, have started menstrual cycle?	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	27. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
14. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	28. Have a history of being afraid of the dark?	<input type="checkbox"/>	<input type="checkbox"/>

Please explain any "yes" answers, noting the number of the question & explain any fears/problems that are not listed _____

Is this your child's first time away from home? _____

Which of the following has the camper had?
 Measles Chicken pox
 German Mumps
 Measles Hepatitis A
 Hepatitis B Hepatitis C
TB Mantoux Test
Date of last test _____
Result: Positive Negative
When was your child's last tetanus shot?
Month _____ Year _____
Are all immunizations (required for school) current and up to date? Yes No

Can non-aspirin medication be given to your child? _____
Dosage _____
Preference? (Tylenol or Ibuprofen) _____
Can stomach relief (such as Pepto-Bismol) be given? _____
Dosage _____
Can Allergy Medication (such as Benadryl) be given? _____
Dosage _____

Use this space to provide any additional information about the camper's behavior and physical, emotional, or mental health which the camp should be aware. _____

Name of family physician _____ Phone _____
Address _____
Name of family dentist/orthodontist _____ Phone _____
Address _____

Screening Record (For camp use only) Screened by _____
Updates/additions to health history Yes None required
Meds Received _____
Additional Notes _____