Wonder Valley
Outdoor Education Center

# Health Examination Form

**NOTE TO PARENTS: STUDENTS UNDER THE AGE OF 18 WILL NOT BE ACCEPTED WITHOUT A COMPLETED HEALTH FORM. THIS IS FOR YOUR PROTECTION. PLEASE NOTIFY THE CAMP IF THIS CHILD IS EXPOSED TO ANY COMMUNICABLE DISEASE DURING THE THREE WEEKS PRIOR TO CAMP ATTENDANCE.**

Student Information:
Last Name:_____ First Name:_____

Age :_____ Birthdate:____/____/_____ School Name: _____

Guardian#1 First and Last Name:_____ Phone #: (____) _____-_____

Address:_____City:_____State:_____ Zip code:_____

_
Guardian #2 First and Last Name:_____ Phone #: (____) _____-_____

Address:_____City:_____State:_____ Zip code:_____

Non-Guardian Emergency Contact :

1. Name:_____Relationship:_____

Address:_____ Phone #: (____) _____-_____

2. Name:_____ Relationship:_____

Address:_____ Phone #: (____) _____-_____

Insurance Carrier:_____ Phone #: (____) _____-_____

Insurance Address:_____

Policy Holder's Name:_____ Policy Holder's Birthdate: ____/____/_____

Relationship to Student:_____ SSN and Insurance ID:_____

Policy #:_____ Group #:_____ RX Bin #:_____

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**Medical Professionals:**

Doctor:_____ Dentist:_____

Orthodontist:_____ Mental Health:_____

Permission To Contact Providers? Yes_____ No_____

| | | | |
|---|---|---|---|
| ___ Abscessed Ears | ___ Bed Wetting | ___ Chest Pains/Dizzy | ___ Skin Problems |
| ___ Glasses/Contacts | ___ Heart Condition | ___ High Blood Pressure | ___ Colds |
| ___ Head Injury | ___ Panic/Anxiety | ___ Poison Ivy/Oak | ___ Whooping Cough |
| ___ German Measles | ___ Clotting/Anemia | ___ Chicken Pox | ___ Lice |
| ___ Mumps | ___ Hepatitis A | ___ HIV | ___ Eating Disorder |
| ___ Back Problems | ___ Hepatitis B | ___ Short Breath | ___ Tuberculosis |
| ___ ADD/ADHD | ___ Hepatitis C | ___ Constipation | ___ Measles |
| ___ H1N1 | ___ Poliomyelitis | ___ Sinusitis | ___ Mono (Last 12 months) |
| ___ OCD | ___ Rheumatic Fever | ___ Depression | |
| ___ Asthma | ___ Seizures | ___ Ehlers Danlos | |
| ___ Athlete's Foot | ___ Bronchitis | ___ Diabetes | |

## Dietary Needs

Please be as specific as possible if the allergy is not listed here:

___ Lactose Intolerance
___ Milk Protein Allergy
___ Vegetarian - w/Dairy ___
___ Vegan
___ Tree Nut Allergy
___ Peanut Allergy
___ Other Nut Allergy _____
___ Shellfish Allergy
___ Sesame Allergy
___ Gluten Intolerance
___ Celiac Disease
___ Other: _____

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I Attest That All My Child's Immunizations Required for School Are Up To Date: Yes_____ No_____

Operations or Serious Injuries:_____
Allergic Reactions: Bee Stings:_____ Penicillin: _____ Other: _____
Details of Above or Additional Information:

_____

Any Specific Activities or Medications To Be Restricted:

_____

**Over The Counter Medications:**
Parents/Guardians, please note, any boxes that are checked indicate that you would **NOT** like your child to have these medications administered by our camp nurse in the event that they are feeling unwell/ill and visit the health center. If you have checked these boxes, we will **NOT** be able to administer that medication to your child while they are at Outdoor Education camp with us. Please be sure that you do **NOT** check any boxes for medications your camper is allowed to have.

| | | |
|---|---|---|
| ____ Acetaminophen (Tylenol) | ____ Antidiarrheal (Maalox) | ____ Bismuth Subsalicylate (Pepto) |
| ____ Calamine Lotion | ____ Chamomile Tea | ____ Cough Drops |
| ____ Ibuprofen (Advil) | ____ Tolnaftate (Tinactin) | ____ Guaifenesin (Mucinex) |
| ____ Diphenhydramine (Benadryl) | ____ Chlorpheniramine Maleate (Robitussin Cough & Allergy Syrup) | ____ Pseudoephedrine Hydrochloride (Advil Cold & Sinus Products) |

**Will your child be bringing any medications to camp?** ☐ Yes ☐ No

**Please fill out the attached Medication Form for <u>EACH</u> medication your child will bring to camp**

**IN CASE OF AN EMERGENCY: I HERBY GIVE MY PERMISSION TO THE PHYSICIAN SELECTED BY Western Camps Inc. TO HOSPITALIZE, SECURE PROPER TREATMENT FOR, AND TO ORDER INJECTION, ANESTHESIA OR SURGERY FOR MY CHILD, AS NAMED ABOVE.**

SIGNATURE:_____
DATE:_____

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# Medication Form

**Name of student**: _____

***All medications (including all OTC meds such as vitamins, Tylenol, Advil, etc.) must be clearly labeled with the student's name, name of medication and instructions. Infirmary staff will not give medications not properly labeled.***

## Medication Name:_____

**Reason for taking (diagnosis):** _____

**Dose:** _____

**Medication is to be taken**

___ Only as needed
___ Daily
___ Other: _____

**How often:**

___ Breakfast (8:30-9am)
___ Lunch (11:30-noon)
___ Dinner (5:30-6pm)
___ Before Bedtime (8:30pm-9: l5 pm)
___ Other times: _____

**Administration**:

___ Oral
___ Topical
___ Inhaler
___ Injection
___ Eye drops
___ Ear drops
___ Other"_____ _____ _____

**Please also answer the following questions:**

When is the first dose to be taken at camp?
_____

Can medication time be changed to accommodate student's schedule? (ie:10:00AM to Lunch)
___ Yes ___ No

Is the label on RX the same as instructions on this form?
___ Yes ___ No, why?
_____

Is medication to be taken throughout student's stay?
___ Yes ___ No

**This form should be completed for each medication brought with your child.**