Health History and Examination for Children, Youth and Adults Attending Camp Wildwood

Mail this form to the address below by *June 1, 2018*

CAMP WILDWOOD
318 Wildwood Road
Bridgton, Maine 04009

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. This form, except for the "Health Recommendations of Licensed Medical Personnel," to be filled in by parents/guardians of minors or by adults themselves.

Name_____**Birth Date**_____**Age**_____

Home address_____
Street address *City* *State* *Zip*

Social security number of participant_____

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 or guardian or emergency contact_____

Address_____**Phone**_____
Street address *City* *State* *Zip*

Business address_____**Phone**_____

If not available in an emergency, notify:

Name_____

Relationship_____**Phone**_____

Address_____
Street address *City* *State* *Zip*

Important - These boxes must be complete for attendance

This health history is correct and complete as far as I know. The person herein named has permission to engage in all camp activities except as noted.
I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for me/my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.
It is my intention that the camp be treated as acting in *loco parentis* if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the purposes of disclosing protected health in-formation pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR § 164.510(b)) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: (i) to provide relevant information to the camp representatives related to the person's ability to participate in camp activities; and (ii) in the case of minors, to
provide relevant information to the camp representatives to keep me informed of my child's health status.
In the event I cannot be reached in an emergency, I hereby give per-mission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent or guardian or adult camper/staffer _____ **Date**_____

I also understand and agree to abide by the restrictions placed on my camp activities.

Signature of minor or adult camper/staffer_____**Date**_____

Health History

The following information must be filled in by the parent/guardian, or adult camper or staff member. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon the participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

Are there any current physical, mental, or psychological considerations that the camp should be made aware of:

_____

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

Medication allergies (list)

_____ _____

_____ _____

Food allergies (list)

_____ _____

Other allergies (list) - include insect stings, hay fever, asthma, animal dander, etc.

_____ _____

_____ _____

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter 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**

☐ **This person takes medication as follows:**

Med #1_____ **Dosage**_____ **Specific times taken each day**_____

Reason for taking_____

Med #2_____**Dosage**_____ **Specific times taken each day**_____

Reason for taking_____

Med #3_____**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.

DIETARY

☐ **Does not eat red meat** ☐ **Does not eat pork** ☐ **Does not eat eggs**

☐ **Does not eat poultry** ☐ **Does not eat seafood** ☐ **Does not eat dairy products**

Other (describe)_____

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)

_____
_____

Health Care Recommendations by Licensed Medical Personnel

I have examined the above camp participant. Date of last examination_____
BP_____ Weight_____ Height_____
In my opinion, the above applicant ☐ is ☐ is not able to participate in an active camp program.
The applicant is under the care of a physician for the following conditions

_____
_____

Current treatment at the time of this report includes

_____
_____

Recommendations and Restrictions at Camp

Treatment to be continued at camp

_____
_____

Medications to be administered at camp (name, dosage, frequency)

_____
_____

Any medically-prescribed meal plan or dietary restrictions

_____
_____

Known allergies

_____
_____

Description of any limitation or restriction on

_____
_____

Additional information for health care staff at the camp

_____
_____

Signature of Licensed Medical Personnel_____

Printed_____ Title_____

Address_____

Phone_____ Date_____

For camp use only

Screening Record

Date screened_____ Time _____

Meds received_____

Updates/additions to health history noted ☐ Yes ☐ No ☐ None required

Current health needs identified_____

Observational notes_____

Screened by_____

General Questions (Explain "yes" answers below.)

Has/ does the participant:

		Yes	No			Yes	No
1.	Had any recent injury, illness or infectious disease?	☐	☐	15.	Ever been diagnosed with a heart murmur?	☐	☐
2.	Have a chronic or recurring illness/condition?. .	☐	☐	16.	Ever had back problems?	☐	☐
3.	Ever been hospitalized?	☐	☐	17.	Ever had problems with joints(e.g., knees, ankles)?	☐	☐
4.	Ever had surgery?	☐	☐	18.	Have an orthodontic appliance being brought to camp?	☐	☐
5.	Have frequent headaches?	☐	☐	19.	Have any skin problems (e.g., itching, rash, acne)?	☐	☐
6.	Ever had a head injury?	☐	☐	20.	Have diabetes?	☐	☐
7.	Ever been knocked unconscious?	☐	☐	21.	Have asthma?	☐	☐
8.	Wear glasses, contacts or protective eye wear?	☐	☐	22.	Had mononucleosis in the past 12 months?	☐	☐
9.	Ever had frequent ear infections?	☐	☐	23.	Had problems with diarrhea/constipation?	☐	☐
10.	Ever passed out during or after exercise?	☐	☐	24.	Have problems with sleepwalking?	☐	☐
11.	Ever been dizzy during or after exercise?	☐	☐	25.	Have a history of bed-wetting?	☐	☐
12.	Ever had seizures?	☐	☐	26.	Ever had an eating disorder?	☐	☐
13.	Ever had chest pain during or after exercise?.	☐	☐	27.	Ever had emotional difficulties for which professional help was sought?	☐	☐
14.	Ever had high blood pressure?	☐	☐	28.			

Please explain any "yes" answers, noting the number of the questions.

_____

_____

Please give all dates of school required immunizations and actual date of last TETANUS shot:

Vaccine	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP							
TD(tetanus/diptheria)							
Tetanus							
Polio							
MMR							
or Measles							
or Mumps							
or Rubella							
Haemophilus influenza B							
Hepatitis							
Varicella (chicken pox)							
BCG							
H1N1 (swine flu)							

Which of the following has the participant had :

Measles ☐ **Chicken Pox** ☐ **German Measles** ☐ **Mumps** ☐ **Hepatitis** ☐

TB Mantoux Test
Date of last test_____
Result: **Positive** ☐ **Negative** ☐

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

_____

_____

Name of family physician _____ **Phone**_____

Address _____

Name of family dentist/orthodontist _____ **Phone**_____

Address _____

Parent/Guardian Authorizations: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted.

Signed **Printed** **Date**

MEDICAL INSURANCE INFORMATION

The information below is required by the medical providers and the pharmacies we utilize and with whom we have established relationships to ensure the most prompt and professional health care available. In case of accident or sickness, we will submit your insurance information directly to all medical providers. If payment is required at time of service, or for any prescriptions the camp will submit your credit card information to pay the provider directly.
(If not applicable, please leave blank.)

CAMPER NAME(S) _____

Name of Insurance Company _____

Group / Policy Number _____

Type of Plan _____

Address and phone number for submitting claims:

_____

Phone: _____--_____--_____

Co-pay Amount $_____ Expiration Date on Card _____

Member's Name _____

Member's Company (if policy issued thru work) _____

Member's ID # _____

Member's Date of Birth _____--_____--_____

Member's Social Security # _____--_____--_____

Member's relationship to camper _____

1. Camper's ID # (if different) _____

YOUR INSURANCE CARD

FRONT BACK

CREDIT CARD INFORMATION

As mentioned above; if payment is required at time of service, or if any prescriptions are to be filled, the camp will submit your credit card information to pay the provider directly.

YOUR CREDIT CARD

1.	**Name on card:**	
2.	**Card Type:(VISA, AMEX, MC,)**	
3.	**Card #:**	
4.	**Expiration Date:**	
5.	**Security code:**	

FRONT BACK

Dear Wildwood Parent:

It is important for you to be aware of a Maine State law that could affect your son while attending Camp Wildwood.

The State of Maine has passed a law that affects all campers who need to have readily available (carry or possess outside of the regular supervision of the camp's health staff) and to self-administer emergency medication while at camp. The law establishes procedures to allow such access to emergency medication by those campers who have been diagnosed to be at risk for a potential medical crisis such as asthmatic attacks or allergic reactions. These medications include, but are not limited to, an asthma inhaler or an epinephrine (epi) pen.

To comply with State Law 2496, all Maine camps are required to have a written policy authorizing campers to have readily available and to self-administer such emergency medications where the following conditions are met.

A. Any camper who self-administers emergency medication must have the prior written approval of the camper's primary health care provider and the camper's parent or guardian:

B. The camper's parent or guardian must submit written verification to the camp from the camper's primary health care provider confirming that the camper has the knowledge and the skills to safely self-administer the emergency medication in camp;

C. The Camp Wildwood's health staff must evaluate the camper's technique to ensure proper and effective use of the emergency medication in camp; and

D. The emergency medication must be readily available to the camper.

If your child needs to, and you want to permit your child to have readily available (carry or possess outside of the regular supervision of the camp's health staff) and to self-administer an inhaler, an epi-pen or other emergency medication, you and your son's primary health care provider must complete and return to us the forms attached with this letter. These forms were developed in cooperation with the Maine Youth Camping Association. When your son arrives at camp our health staff is required to evaluate his self administration technique to ensure proper and effective use.

These forms are not necessary for those campers who do not need to have readily available and to self-administer emergency medications. As always our health staff will provide regular supervision of prescription medications for campers.

All forms should be returned to our office by June 18, 2018, via fax (207)647-5656 or mail. As always, please call with any questions or concerns. Thank you in advance for helping us comply with this new law.

Thank you,

Louis, Teddy, Mark, Peter

PERMISSION FORM

APPROVAL FOR CARRYING AND SELF-ADMINISTERING EMERGENCY MEDICATION

As the primary health care provider for (camper's name) _____, I order the carrying and self-administering, as medically necessary of the following medications by the above named camper: (Check all that apply or list other emergency self-medication device.)

- Asthma Inhaler ☐
- Epinephrine Pen ☐
- Other (please list)_____

Further, I confirm that this camper has the knowledge and the skills to carry and safely self-administer the indicated emergency medication in camp.

_____ _____
Primary Healthcare Provider signature Date

PARENT PERMISSION FORM

USE OF SELF-ADMINISTERED EMERGENCY MEDICATION

As the parent or guardian of (camper's name) _____ I approve of the carrying and self-administering, as medically necessary of the medications listed above by my child:

Further, I confirm that my child has the knowledge and the skills to safely carry and self-administer the above listed emergency medication in camp.

_____ _____
Parent or Guardian signature Date