Winding Trails, Inc.

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Farmington, CT 06032
Phone: (860) 674-4227 Fax: (860) 676-9407

2008 Annual Health History & Examination Form

This side is to be completed ANNUALLY by parents/guardians of campers or by adult staff members.

Camper Name ______________________________ Birthdate __________ Sex ______ Age __________
Last First Initial

Home Address ____
Street & Number City State Zip

1st Parent Name ____________________ Home Phone __________ Cell Phone __________ Work Phone __________

2nd Parent Name ____________________ Home Phone __________ Cell Phone __________ Work Phone __________

Emergency Contact ____________________ Home Phone __________ Cell Phone __________ Work Phone __________

In what order would you like us to contact you? ______________________________

Health History:
(Check. Give approximate dates.)
_____ Frequent Ear Infections
_____ Heart Defect/Disease
_____ Convulsions
_____ Diabetes
_____ Bleeding/Clotting Disorders
_____ Hypertension
_____ Mononucleosis
_____ Psychiatric Treatment

Diseases
_____ Chicken Pox
_____ Measles
_____ German Measles
_____ Mumps

Allergies (Dates not needed)
_____ Hay Fever
_____ Ivy Poisoning, etc.
_____ Insect Stings
_____ Penicillin
_____ Other Drugs
_____ Asthma
_____ Other (Specify) __________

Has this camper been on any medication within the last six months? __________
If yes, please explain. ______________________________
Has this camper ever required any psychiatric counseling or hospitalization? ___
Explain ______________________________
____
Operations or serious injuries (dates) ______________________________
Disability or chronic or recurring illness ______________________________
Activities encouraged or limited by physician ______________________________
Dietary modifications ______________________________
Current medications (send with instructions) ______________________________
Other diseases or details of above ______________________________
Name of dentist / orthodontist ____________________ Phone __________
Name of family physician ____________________ Phone __________
Date of last physical examination ______________________________
Do you carry family medical/hospital insurance? Yes ☐ No ☐
If so, indicate: Carrier ____________________ Policy or Group # __________
Suggestions or health related information for camp personnel ______________
For Female
Has this person menstruated? ______ If not, has she been told about it? _______
If so, is her menstrual history normal? ______ Special Consideration __________
Does your child have permission to self administer medication. Yes ☐ No ☐

Please indicate which, if any, of the following your child may be given at camp.
Acetaminophen _____ Ibuprophen _____ Sudaphene _____
Benedryl _____ Calamine _____ Bacitracin _____ Antacid _____
Insect Repellent _____ Sunscreen_____ Throat Lozenges _____

Important - The Box Below Must be Completed Annually for Attendance *

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted. **Authorization for Treatment:** I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment and necessary transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for my child as named above. The completed forms may be photocopied for trips out of camp.
Signature of parent or guardian or adult camper/staffer ______________________________
Date ____________________

* If for religious reasons you cannot sign this, then the camp must be contacted for a legal waiver which must be signed for attendance.

Physical Examination Form on Reverse Side

Physical Examination Form: To be completed by a physician

Camper Name ________________________________ ***D.O.B.*** ___________________ ***Date*** ______________

Physician: Complete this page OR attach an equivalent form (i.e. Youth Camp Health Exam)

Immunization History

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

Vaccines	Year of Basic Immunization	Year of Last Booster
DTP		
DTP/Hib		
DTaP		
DT/Td		
OPV		
IPV		
MMR		
Measles		
Mumps		
Rubella		
HIB		
Hep B		
Varicella		
PCV		
Meningitis		

Health Care Recommendations by Licensed Physician

I have examined the above camp applicant within the past two years. Date Examined ________________

In my opinion, the above's condition ☐ does ☐ does not prevent his/her participation in an active camp program.

Height _______________ Weight _______________ Blood Pressure ____________________

The applicant is under the care of a physician for the following condition(s):

____

____

Current treatment (include current medications)

____

Explanation of any reported loss of consciousness, convulsion or concussion ______________________________

____

Does applicant have epilepsy? ☐ Yes ☐ No Does applicant have diabetes? ☐ Yes ☐ No

Recommendations and Restrictions While at Camp

Any treatment to be continued at camp ____

____

Any medications to be administered at camp (specific dosages) ______________________________

____

Any medically prescribed meal plan or dietary restrictions ______________________________

____

Any allergies (food, drug, plants, insects, etc.) ______________________________________

____

Additional Health Information ____

____

Licensed Physician's Signature ____

Address ____ Phone ______________

Street & Number City State Zip Area/Number

Date of Form Completion ____________________ *By ______________________________

* Initial if completed by nurse or physician's assistant