

Name (Last): _____ (First) _____
W1 _____ W2 _____ W3 _____ W4 _____ W5 _____ W6 _____

For camp personnel use only



Summer Address: 100 Sandy Pond Road, Richmond, NH 03470 Phone: (603) 239-4841
Winter Address: c/o Athol Area YMCA, 545 Main Street, Athol, MA 01331 Phone: (978) 249-3305
FAX (978) 249-4009 E-mail: campwiyaka@yahoo.com

Name: _____

Age at camp: _____ Date of Birth: _____ Sex: _____

Address: _____

Daytime Phone: _____ Evening Phone: _____

Contact Information:

Custodial Parent/Guardian: _____

Address: _____

Daytime Phone: _____ Evening Phone: _____

Second Parent/Guardian: _____

Address (if different from above): _____

Daytime Phone: _____ Evening Phone: _____

If not available in an emergency, notify: _____

Relationship: _____ Phone: _____

Address: _____

Do you have plans to be away from home (other than work) during the camper's stay? Yes No

If so, please remember to attach dates, location, and contact information.

Insurance: Is the participant covered by medical/hospital insurance? Yes No

Insurance Company: _____

Plan or Group #: _____

Cardholders Name: _____ Employer Carrier _____

The CAMP insurance is the secondary insurance. The above insurance play will be used first.

Doctor: _____ Phone: _____

Dentist/Orthodontist: _____ Phone: _____

Health History: The following information must be completed by a parent/guardian. Any changes to this form should be provided to the camp health personnel upon participant's arrival at camp.

Allergies: Please list all known and describe reaction and management of this reaction

Medication: _____ Reaction: _____

Food: _____ Reaction: _____

Environmental: _____ Reaction: _____

Other Allergies: _____

Are there any physical, emotional, or behavioral issues Camp Wiyaka should be aware of? Recent or ongoing medical treatment? Yes (please explain below) No

Restrictions:

Dietary Restrictions: None Does not eat: Dairy Red meat Poultry Seafood Pork Eggs

Other: _____

Activity Restrictions: (what cannot be done, necessary limitations or adaptations, reason for restriction)

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

Signature of camper: _____ **Date:** _____

Does your son/daughter have problems with any of the following: Check all that apply

- | | | | |
|---------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------------|-----------------------------------------|
| 1. Fainting <input type="checkbox"/> | 2. Sleep Disturbances <input type="checkbox"/> | 3. Constipation <input type="checkbox"/> | 4. Bed Wetting <input type="checkbox"/> |
| 5. Heart Disease <input type="checkbox"/> | 6. Mononucleosis <input type="checkbox"/> | 7. Hay Fever <input type="checkbox"/> | 8. Asthma <input type="checkbox"/> |
| 9. Insect Stings <input type="checkbox"/> | 10. Poison Ivy/Oak etc. <input type="checkbox"/> | 11. Menstruation <input type="checkbox"/> | 12. Headaches <input type="checkbox"/> |
| 13. Seizures <input type="checkbox"/> | 14. Eating Disorders <input type="checkbox"/> | 15. Emotional Difficulties <input type="checkbox"/> | |
| 16. Recent injury, illness, or infection disease <input type="checkbox"/> | | 17. Chronic or recurring illness/ condition <input type="checkbox"/> | |

Please explain any that are checked, noting the number: _____

Childhood Diseases:	Chicken Pox	Yes	No	German Measles	Yes	No
Circle the correct answer	Measles	Yes	No	Mumps	Yes	No
	Hepatitis A	Yes	No	Hepatitis B	Yes	No
	Hepatitis C	Yes	No			

CAMP WIYAKA, INC. HEALTH HISTORY RECORD (CONTINUED)

Medications: Please list all medications including over the counter and non-prescription drugs taken routinely. Bring enough medication to last the entire time at camp. All medications must be brought in their original containers that identify the prescribing physician, name of medication, dosage, and frequency of administration.

This person takes NO medication on a routine basis

This person takes the following medications

Med #1 _____ Dossage _____ Time taken each day _____

Reason for medication _____

Med #2 _____ Dossage _____ Time taken each day _____

Reason for medication _____

Med #3 _____ Dossage _____ Time taken each day _____

Reason for medication _____

Attach additional pages if necessary.

Identify any medications taken during the school year that participant does not take during the summer.

I give permission for Camp Wiyaka to administer the following over the counter medications for their indicated usage. (Check all that apply)

- | | | |
|---------------------------------------------------------|-----------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Tylenol (children’s & adult’s) | <input type="checkbox"/> Calamine Lotion | <input type="checkbox"/> Triacting Cough Medicine |
| <input type="checkbox"/> Motrin (children’s & adult’s) | <input type="checkbox"/> Imodium | <input type="checkbox"/> Robitussin |
| <input type="checkbox"/> Eye Drops | <input type="checkbox"/> Tums | <input type="checkbox"/> Cough Drops |
| <input type="checkbox"/> Sudafed | <input type="checkbox"/> Pepto-Bismol | <input type="checkbox"/> Peroxide |
| <input type="checkbox"/> Benadryl | <input type="checkbox"/> Hydrocortisone Cream | <input type="checkbox"/> Triple Antibiotic Ointment |
| <input type="checkbox"/> Gold Bond Powder | <input type="checkbox"/> Athlete’s Foot Spray | <input type="checkbox"/> Swimmer’s Ear |

Parent Authorization: I attest that this health history is accurate and complete, and that the person described herein has permission to participate in all camp activities except as noted by me or the examining physician. I hereby give permission to Camp Wiyaka to provide routine health care, including prescribed medication, and seek emergency medical treatment, including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission for Camp Wiyaka to arrange necessary related transportation for me/my child. If I cannot be reached in an emergency, I hereby grant permission to the physician selected by Camp Wiyaka to secure and administer treatment, including hospitalization, for the above named person. This completed form may be photocopied for use on trips out of camp.

Parent/Guardian Signature _____ Date: _____

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PHYSICAL EXAMINATION

MUST BE COMPLETED BY YOUR PRIMARY CARE PROVIDER

EXAMINATION FOR ANOTHER PURPOSE WITHIN THE PAST 12 MONTHS IS ACCEPTABLE
PROVIDING THERE HAS NOT BEEN A MAJOR ILLNESS SINCE THAT EXAM

Name: _____

Date of Birth: _____ Height: _____ Weight: _____ BP _____

Immunizations:

Please give all dates of immunizations for:

Vaccine:	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP		_____	_____	_____	_____	_____	_____
TD		_____	_____	_____	_____	_____	_____
Tetnus		_____	_____	_____	_____	_____	_____
Polio		_____	_____	_____	_____	_____	_____
MMR		_____	_____	_____	_____	_____	_____
Heamophilus influenza B		_____	_____	_____	_____	_____	_____
Heepatitis B		_____	_____	_____	_____	_____	_____
Varicella		_____	_____	_____	_____	_____	_____

TB Mantoux Test Date: _____ Positive Negative

Physical Exam (1 = satisfactory 2 = unsatisfactory 3 = not examined)

Skin _____ Eyes _____ Glasses/Contacts? _____ Skeletal _____
 Throat _____ Teeth _____ Mouth _____ Nose _____
 Ears _____ Tubes _____ Hearing (R) _____ Hearing (L) _____
 Heart _____ Murmer _____ Lungs _____
 Abdomen _____ Hernia _____ Genitalia _____

Comments: _____

CAMP WIYAKA, INC. HEALTH EXAMINATION RECORD (CONTINUED)

Recommendations / Restrictions while at camp:

Treatments to be continued at Camp: _____

Known allergies, including reaction and treatment of reaction: _____

Description of any limitation or restrictions on camp activities: _____

Medically-prescribed meal plan or dietary restrictions: _____

Additional information for the health care staff at camp: _____

The above named person is under the care of a physician for the following conditions: _____

In my opinion, the above named person is is not able to participate in an active camp program except as noted above.

Signature of Primary Care Provider: _____

Printed Name: _____ Title: _____

Address: _____

Phone: _____ Date: _____