Health History & Medical Information

Front of form must be completed by parent & signed within 6 months of camp attendance every year.
Back of form must be completed by physician with physical information taken within 24 months of camp attendance

Return to: Camp Wildbrook
9664 Daly Rd.
Cincinnati, OH 45231
Due by: June 1st

This side to be filled in by parent/guardian of minors.

Camper____ _____ Birth Date_____ Sex_____ Age_____
Last First I.

Parent/Guardian Name_____ Home Phone_____
Area Code/Number

Home Address_____ Cell Phone _____
Street City State Zip Area Code/Number

Work Address_____ Work Phone_____
Street City State Zip Area Code/Number

Second/Parent Guardian or Emergency Contact: _____ Home Phone_____
Area Code/Number

Home Address_____ Cell Phone _____
Street City State Zip Area Code/Number

Work Address_____ Work Phone_____
Street City State Zip Area Code/Number

If not available in an emergency, notify:
Name_____ Relationship_____

Address_____ Phone_____
Street City State Zip Area Code/Number

Health History:
Check/list approximate dates

Frequent Ear Infection _____
Heart Defect/Disease _____
Convulsions _____
Diabetes _____
Bleeding/Clotting _____
Hypertension _____
Diseases
Chicken Pox _____
Measles _____
German Measles _____
Mumps _____
Allergies
Hay Fever _____
Insect Stings _____
Penicillin _____
Other Drugs _____
Asthma _____

Dentist/Orthodontist:_____ Phone:_____

Family Physician:_____ Phone:_____
Date of last physical examination:_____

Past medical treatment (include operations, injuries, and illnesses):_____
_____

Current disability/health condition which would exempt participation in the following specified camp activities :_____

Dietary Modifications: (check) **Kosher**_____**Vegetarian**_____**Food Allergy/ Other (**specify)___
_____

Current Medications (prescription/over-the-counter) (send instructions on Wildbrook Medication Form):_____

Any treatment/medications/restrictions (for physical, mental, or psychological conditions that need to be continues while at camp_____

For Female: Has person menstruated?_____ If not, has she been told about it?____ If so, is her menstrual history normal?_____ Special Considerations: _____

Do you carry family medical/hospital insurance?_____ Carrier:_____ Policy or Group#_____

Camper:_____ Group:_____ Year:_____

IMPORTANT - THIS BOX MUST BE COMPLETED BY PARENT

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.
1)AUTHORIZATION TO SHARE CAMPER MEDICAL INFORMATION with camp staff to insure camper safety (i.e. allergies, hearing loss, diabetes, seizure activity, etc.)
2)AUTHORIZATION FOR TREATMENT: I hereby give permission to the Wildbrook staff to administer first aid for minor injuries and illnesses and permission to the medical/mental health personnel selected by camp director to order X-rays, routine tests, treatment, counseling; to release any records necessary for insurance purposes; and to provide or arrange 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 the person named above. The completed forms may be photocopied for trips out of camp.

Signature of parent/guardian _____ Date_____

I also understand & agree to abide with restrictions placed on my camp activities. Signature of minor:_____ Date_____

Immunization History **Campers Name**_____

Required immunizations must be determined locally. Please record date of basic immunizations and most recent booster dates **or include** an immunization waiver.

Vaccines	Year of Basic Immunization	Year of lst Booster
Diptheria Pertussis (Whooping Cough) DPT Tetanus	1. 2. 3.	1. 2.
Tetanus Diphtheria TD		
Tetanus		
Oral Polio (Sabin) TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measles, Rubella		
Other		
Tuberculin test given _____ (most recent)		
Haemophilus influenza b (HIB)		
Hepatitis B		

HEALTH EXAMINATION BY LICENSED PHYSICIAN:

I have examined the above child within the past 2 years. **Exam Date**:_____

Date of Last Tetanus:_____ **Child's immunizations up-to-date? Yes_____ No_____**

Height_____ Weight_____ Blood Pressure_____

In my opinion, the above's condition does____/does not____ preclude his/her participation in an active camp program.

The child is under the care of a physician for the following physical, mental, or psychological conditions: _____

_____

Current treatment (include current prescription and over-the-counter medications): _____

Explanation of any reported loss of consciousness, convulsions, or concussion: _____

_____

Does child have epilepsy? Yes_____ No_____ Does child have diabetes? Yes_____ No_____

RECOMMENDATIONS AND RESTRICTIONS WHILE AT CAMP

Any treatment/medications (for physical, mental, or psychological conditions) to be continued at camp (specific instructions):_____

_____

_____

Any medically prescribed meal plan or dietary restrictions **including** religiously/self selected dietary modifications:_____

_____

Any allergies (food, drugs, plants & insects, etc.): _____

_____

Activities to be encouraged or limited: _____

Additional Health Information: _____

_____

Licensed Physician's Signature_____ Phone_____
Area Code/Number

Address _____
Street City State Zip

Date of Form Completion_____ *By_____
Initial if completed by nurse or physician's assistant