Camper Health Form Part I & II (Parents)
Part III (Physician)

Part I

Camper Name:_____ Birthdate: _____ Sex: M - F Age:____

Last Name First Name MM/DD/YYYY Circle one

Parent/Guardian Name: _____ Email Address:_____

Cell Phone: (_____)_____ Home Phone: (_____)_____

Home Address:_____

Street & Number City State or country Zip Code

If not available in an emergency notify:

Name:_____Relationship to Camper_____ Phone: (_____)_____

Address:_____

Street & Number City State or country Zip Code

HEALTH HISTORY: If you answer yes please give detail in the space below.

Ever been hospitalized?	Y___ N___	Had mononucleosis ("mono") during the past 12 months?	Y___ N___
Ever had surgery?	Y___ N___	Had/have asthma/wheezing/shortness of breath?	Y___ N___
Have recurrent/chronic illness?	Y___ N___	Wear glasses, contacts or protective eyewear?	Y___ N___
Have recurrent infectious disease?	Y___ N___	Have problems falling asleep/sleepwalking?	Y___ N___
Had a recent injury?	Y___ N___	Ever had back or joint problems?	Y___ N___
Have diabetes?	Y___ N___	Have a history of bedwetting?	Y___ N___
Had/have seizures?	Y___ N___	Have problems with diarrhea/constipation?	Y___ N___
Had fainting or dizziness?	Y___ N___	Have any skin problems?	Y___ N___
Have headaches?	Y___ N___	Have any ear infections/swimmers ear?	Y___ N___
Passed out/had chest pain during exercise?	Y___ N___	Traveled outside the Unite States in the past 9 months?	Y___ N___
Please explain "Yes" answers below:		If yes please list the countries_____	

Allergies

☐ NO Known Allergies

☐ This camper is allergic to - Food____ Medicine____ Environment (insects, plants, seasonal)____ Other____

If Allergic please give specific allergy, reaction, and action plan and medication.

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Camper Health Form Part II

Medications

☐ Camper will not take any daily medications while attending camp.
☐ Camper will take the following daily medication while at camp:

Medication	Reason for Taking	When to be given BK/Lunch/Dinner/Bed/Other	Dosage

Restrictions

☐ I have reviewed the program and activities and feel my camper can participate in all activities without restrictions.
☐ I have reviewed the program and activities and feel my camper can participate with the following restriction:

Diet

☐ Camper eats a regular diet
☐ Camper has a special food needs *(Please Describe)*

Mental, Emotional and Social Health

Ever been treated for attention deficit disorder(ADD) or attention deficit/hyperactivity disorder(AD/HD)? Y____ N____
Ever been treated for emotional or behavioral difficulties or eating disorder? Y____ N____
During the past 12 months have you seen a professional to address mental/emotional health concerns? Y____ N____
Had a significant life event that continues to effect the camper's life Y____ N____
Please explain "Yes" answers below:

Any additional information about your camper or their health that you think important to share with the camp staff for the success of your camper in the program?

Health Insurance Information

Insurance Company Name_____ Policy Number_____
Name of Insured_____ Relationship to camper_____
Insurance Company Phone Number_(____)_____

Parental Authorization

The health history, health examination, and insurance information are correct as far as I know, and my child as named has permission to engage in all camp activities, except as noted by me and the examining physician. I also give permission for my child to participate in wilderness swimming which will be taking place in the Western Adirondack State Park during hiking and/or boating trips in remote areas that are not readily accessible for inspection to the local health department, the swim areas selected will be inspected by camp staff for safety in regards to clarity, depth and current. In the event I cannot be reached in an EMERGENCY, I hereby give permission to the physician selected by the Camp Director to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child as named. I understand the information on this form will be shared on a need to know basis with camp staff. The camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the staff about my child's health status. I give permission for my child to carry and use any FDA approved over the counter sun screen for protection from the sun and to carry and use all insect repellants unless otherwise noted on my health form under Part III.

Parent/Guardian Signature_____Date_____

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Camper Health Form Part III

Over the Counter Medications

For your camper's future medical needs at Woodcraft the NYS Department of Health requires direction from your family doctor for us to administer any over the counter medications on an as needed basis. Below is a list of commonly used drugs for your doctor's approval. If there are any additional drugs your doctor thinks are appropriate please include them at the end.

To be completed by camper's Licensed Physician	Physician's Approval	
	YES	NO
Swimmer's Ear: Isopropyl Alcohol 1-2 drops every 4 hours		
After Bite or Diphenhydramine HCL 2% for insect bites/itch relief		
Bug/Insect Repellent: to prevent bug bites		
Parents please list any brand/type not acceptable by you:		
Alcohol wipes: for cleaning small wounds		
Betadine: for cleaning small wounds		
Hydrogen Peroxide: for cleaning small wounds		
Sun block: prevention of sun burn		
Moisturizing lip treatment/sun block: prevention		
Antifungal cream: for athlete's foot or for fungal infections		
Ibuprofen: per child's weight/age given every 4-6 hours (*pain, swelling, fever)*		
Acetaminophen: per child's weight/age given every 4-6 hours (*pain, swelling, fever)*		
Diphenhydramine: 25 mg every 4 hours *for minor allergies or minor allergic reaction*		
Hydrocortisone 1% cream: for local/topical skin irritation		
Pseudoephedrine over 12 yrs. age: for stuffy nose due to allergy		
Throat Lozenges: non-medicated, 1 every hour (as needed) for throat irritation		
Antibiotic ointment: for minor cuts/scrapes		
Petroleum Jelly: for minor skin irritations		
Aloe Cream/Cooling gel: for minor burns and sunburn		
Calamine Lotion: for bug bites or poison ivy		
Poison Ivy Cream: for itch and drying		
Lice Treatment Shampoo		
Saline eye wash: for minor eye irritation		
Cough Syrup: use as directed		
Please add any additional medication approved by a physician:		

Continues on next page with signature required

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Camper Health Form Part III - Continued

To be completed by camper's Licensed Physician

MEDICAL EXAMINATION

This examination should be performed within 12 months of arrival at camp. Examination for some other purpose within this period is acceptable. Examination is to determine fitness to engage in strenuous activity.

Code:
S = Satisfactory **X = Not satisfactory (explain)** **O = Not Examined**

Eyes	_____	Teeth	_____	Extremities	_____	Height	_____
Glasses	_____	Heart	_____	Posture(Spine)	_____	Weight	_____
Ears	_____	Lungs	_____	Skin	_____	Blood Pressure	_____
Nose	_____	Abdomen	_____	Urinalysis	_____	Hgb. Test	_____
Throat	_____	Hernia	_____	Allergy (Specify)	_____	General appraisal	_____

Do you feel the camper should have limitations or restrictions to any camp activities? Y_____ N_____
If you answered "Yes" please describe the suggested restrictions.

IMMUNIZATION HISTORY

Required immunization must be determined locally. This is a record of dates of basic immunizations and most recent booster doses. Attach a copy of immunization record if available.

DDT Series	_____	Booster	_____	Polio	_____	Booster	_____
MMR	_____	Hepatitis B	_____	Hepatitis A	_____	Pneumococcal	_____
Tuberculin Test	_____	Tetanus Booster	_____	Influenza Type B	_____	Varicella (Chicken Pox)	_____

I have examined the person herein described and have reviewed his/her Camper Health Forms. It is my opinion that he/she is physically able to engage in camp activities, except as noted. I have also indicated which over the counter medications are allowable.

Physician's Name (Please Print) _____ **Date** _____

Signature _____ **Phone** _____

Physician's Address: _____

Physician email _____

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