Camp Bil-O-Wood

Medical Form

Camper Name: _____ Sex: M __ F __ Birth date: ___/___/___
Address: _____ Age: ____
City: _____ State: _____ Zip: _____
Religion: ***(required by hospital)*** _____
Parent Information: name: _____ phone (home): _____
(work) :_____(cell) :_____ (fax): _____
Email address:_____
Emergency Contact:_____

Primary Physician: name: _____phone: _____
Address: _____City: _____ State: _____ Zip _____
Date of last Visit: _____

Insurance Information: Company Name: _____
ID/Policy Number: _____ Group number: _____

Immunization History: (please attach copy of immunization record)
MMR: _____ DPTP: _____ Tetanus: _____ HIB: _____
Hep B: _____ TB: _____ Other: _____
Communicable Disease History: (Please check if prior infection)
Chicken pox ___ Measles ___ Mumps ___ Tuberculosis ___ Hepatitis ____ Whooping Cough ___ Mononucleosis ___ Lice ___ Other _____
Major Injury, Illness, or Surgery: (please provide dates)
Injuries: _____
Illness: _____
Surgeries: _____
Chronic Conditions or Health Issues: (please check those which apply)
Asthma ___ Diabetes ___ Allergies ___ Ear aches ___ Sinus infection ___
Headaches ___ Migraines ___ Seizures ___ Fainting ___ Urinary infection ___ Stomach aches ___ Eating Disorder ___ Homesickness ___ Bed Wetting ___ Sleep Walking ___ Vision problems ___ Hearing Problems ___ Emotional Concerns ___ Physical limitation ___ Behavior challenges
Other_____
Please explain any above concerns and describe treatments and/or limitations
_____
_____
_____

Camp Bil-O-Wood has a warm, dry climate and is free of most poisonous vegetation and snakes. Many children who suffer from seasonal & environmental reactions are more comfortable in this environment. A high level of outdoor activity may reduce the need for some medications. **We ask that doctors and parents use good judgment and appropriate evaluation** to determine which medications their child should use during camp.

Medication Information: List any meds to be given ***regularly***:

Name	Dosage	Frequency	Reason

1._____
2._____
3._____

List any medication to be given ***only as needed***:

1._____
2._____

List any medications ***not to be given*** at camp:

Camp Bil-O-Wood provides a full-time health center staffed with a registered nurse and nurse's assistant and has readily available access to a medical doctor and emergency hospital. Our nursing staff will keep and distribute your child's medications as needed. **NO MEDICATIONS ARE TO BE KEPT IN THE CABINS**

Allergy Information: (Please check any that apply and indicate reaction)
Insect bites or stings ___ Animals ___ Antibiotics ____ Foods ___ Drugs ___
Seasonal ___ Other _____
Please indicate reaction and treatment:
_____

Physical Examination: Eye color_____ Hair color____ Height_____
Weight_____ (lbs) ROS_____
Impression_____

Physician Statement:

To the best of my knowledge, the applicant is in good health and is able to participate in all camp activities except as stated above. **I will notify the camp nurse if the applicant is exposed to any infectious or communicable conditions during the four weeks immediately prior to camp or if the child develops any condition that could affect his or her health or another child's health while at camp.**

Physician signature: _____ Date: _____
Printed name: _____

Confidentiality: This report provides confidential information important to the welfare of my child. I give permission to disclose my child's personal health information to those who need it in order to maintain the health and safety of my child.

Signature: _____ Date: _____

Emergency Contact: In case of emergency, I understand that every effort will be made to contact the names listed in the parent information. In the event, that I/we cannot be reached, permission is granted for the physician(s) selected by the camp to provide emergency care to my child as named in this document.

Signature: _____Date:_____

Infection Control: I agree to notify the camp if the named child is exposed to any infectious or communicable diseases during the four weeks immediately prior to camp. **My child has been examined for and is determined to be free of head lice.**

Signature: _____Date:_____