

2007

CAMP WINFIELD HEALTH EXAMINATION FORM

*SECTION A TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN
SECTION B TO BE COMPLETED AND SIGNED BY PHYSICIAN*

SECTION A

Name _____ Attending Session(s) (circle) 1 2
 Birthdate _____ Age _____
 Parent or Guardian _____ Business Phone (_____) _____
 Home Address _____ Home Phone (_____) _____
 City _____ State _____ Zip _____ Fax (_____) _____
 Second Parent/Guardian or Emergency Contact _____
 Home Phone (_____) _____ Business Phone (_____) _____
 If not available in an emergency, notify _____
 Home Phone (_____) _____ Business Phone (_____) _____

CAMPER'S NAME

Last

First

M.I.

Cabin

NO CHILD WILL BE ACCEPTED AS A CAMPER WITHOUT HEALTH INSURANCE OR OFFICIAL PROOF OF MEDICAID

I understand Camp Winfield has no health or accident insurance on campers.

My Health Insurance Company _____

Group # _____ Policy # _____ Phone # _____

Address of Insurance Company _____ City _____ State _____ Zip _____

Please provide a copy of your child's insurance/Medicaid card.

PARENT/CAMPER AGREEMENT:

This health history is correct so far as I know, and the child named above has permission to engage in all prescribed camp activities except as noted. The staff of Camp Winfield exercise caution in the conduct of all camp activities; however, they do not assume responsibility for accidents, injuries, or illnesses suffered by its campers.

I, as a parent or guardian of the child named above, individually and on behalf of the camper, hereby release, discharge, and agree to indemnify Camp Winfield, its directors, and employees from all liability for damage, injury, or illness to the camper or his or her property relating to or deriving from his or her stay at Camp Winfield or participation in travel to or from Camp Winfield activities.

I, as a parent or guardian of the child named above, hereby grant permission to Camp Winfield to use any photographs or video of the camper taken during the camping session in newspapers, magazines, brochures, or other media for promotional purposes.

AUTHORIZATION FOR TREATMENT:

I, as a parent or guardian of the child named above, hereby give permission to the medical or dental personnel selected by the camp to order x-rays, routine tests, treatment for the camper, and necessary transportation for my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, order injections, anesthesia, or surgery, including hospitalization, for the child named above. The completed forms may be photocopied for trips out of camp. I further acknowledge that I will be responsible for payment of all charges related to the medical and dental services provided.

SIGNATURE OF PARENT/GUARDIAN

DATE

Allergies to drugs _____

Any other known allergies _____

Recent exposure to contagious disease(s) Yes _____ No _____

If yes, name of disease(s) and date(s) _____

List any serious or chronic illnesses that the child has ever had. Also list any operations or serious injuries _____

HEALTH HISTORY – Does your child have any of the following? For all yes answers please mark “x” in the box and explain in the space provided. Include your usual method of treatment and have your child bring to camp the medication required.

- | | | | | |
|--|---|--|--|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sleepwalking | <input type="checkbox"/> Frequent sore throats | <input type="checkbox"/> Seizures | <input type="checkbox"/> Stomach upsets |
| <input type="checkbox"/> Reactions to insect bites/stings/poisonous plants | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Ear problems |
| <input type="checkbox"/> Other | <input type="checkbox"/> Skin rashes/problems | <input type="checkbox"/> Asthma | <input type="checkbox"/> Constipation | <input type="checkbox"/> Hayfever/sinus problems |
| | | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Athlete’s foot | |

List medicines taken *daily* including dosages and times: _____

List medicines taken *when necessary*: _____

Describe any other health conditions requiring treatment or restrictions: _____

SECTION B

Every child is required to have a medical examination performed by a physician within **24 months** prior to camp attendance. Section B must be completed and signed by a physician at that time.

Code: Satisfactory
 Not Satisfactory (explain)

Date of examination _____

General condition or Appraisal _____

Height _____ Weight _____ Temp. _____ Blood Pressure _____

Heart _____ Murmur _____ Lungs _____

Urine _____ Blood hemog. _____

Allergies: Animal _____ Food _____ Drugs _____ Other _____

List any current or on-going treatment and/or medications: _____

Please Check One:

_____ I believe this child is able to attend camp and participate in all camp activities.

_____ I believe this child is able to attend camp and participate in all camp activities with the following restrictions and recommendations: _____

Examining Physician Name: _____ Signature: _____

Address _____

Phone (_____) _____ Date _____

IMMUNIZATION RECORD *(To be completed by parent/guardian or physician)*

Which of the following has your child had?

- Measles
- Chicken Pox
- German Measles
- Mumps
- Hepatitis

Please send a copy of the immunization record or complete below, listing the last date vaccine was given:

DTP/DPTA	_____	MMR	_____
Tetanus	_____	Hepatitis B	_____
Polio	_____		

Return Completed Form to: Camp Winfield; PO Box 160 ;Hartwell, GA 30643

By May 15, 2007