

Burgundy Center For Wildlife Studies Health Form 2011

This side to be filled in by parents/guardians of minors or by adult staff members.

Name _____ Birth Date _____ Sex _____ Age _____

Parent(s) or Guardian(s) _____ Phone (H) _____ (W) _____

_____ Phone (H) _____ (W) _____

Home Address _____

Non-Custodial Parent or Emergency Contact _____

Home Address _____ Phone (H) _____ (W) _____

Alternate Emergency Contact: _____

Address _____ Phone (H) _____ (W) _____

THIS BOX MUST BE COMPLETED FOR ATTENDANCE*

This health history is correct so far as I know. I hereby give permission to BCWS:

1. To provide ongoing health care
2. To select medical personnel and to order X-rays or routine tests or treatment for the person listed above.

Emergency Authorization: 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 and/or anesthesia and /or surgery for the person named above. This form may be photocopied for use out of camp.

Signature of parent / guardian (or adult staff) _____

Witness _____ Date _____

I understand and agree to abide with any restrictions my parent or physician has placed on my camp activities.

Signature of minor _____

**If for religious reasons you cannot sign this, then the camp should be contacted for a legal waiver, which must be signed for attendance.*

HEALTH HISTORY (Check all that apply)

<u>General</u>	<u>Allergies</u>	<u>Diseases</u>
Frequent Ear Infections _____	Hay Fever _____	Chicken Pox _____
Heart Defect/Disease _____	Poison Ivy _____	Measles _____
Diabetes _____	Insect stings _____	German Measles _____
Bleeding/Clotting Disorders _____	Penicillin _____	Mumps _____
Hypertension _____	Other _____	
Psychiatric Treatment _____		
Mononucleosis _____		
Epilepsy _____		

Any operation / serious injuries (dates) _____

Reason for any psychiatric counseling or hospitalization _____

Disability or chronic or recurring illness _____

Allergies / Dietary modifications _____

Special treatment / restrictions / considerations / exemptions from camp activities _____

Current medication(s) (each requires a medication form) _____

Does (female) camper have a menstrual cycle? _____ If not, has she been told about it? _____

If so, is her menstrual history normal? _____ Special consideration _____

Name of family physician _____ Phone _____

Name of dentist/orthodontist _____ Phone _____

Date of last physical examination (must be within 24 months of camp attendance) _____

Family medical/hospital insurance carrier _____ Policy # _____

(OVER)

IMMUNIZATION HISTORY

Immunization history must be updated, by a parent or at doctor's office, within one year of camp attendance.

Please record the date (month and year) of most recent booster dose or test:

Vaccine / Test	Date of last booster / test
Tetanus	
Tuberculin test	

Are the following immunizations up-to-date (we do not require the immunizations, but DO need the information):

• polio, measles, mumps, rubella, chicken pox YES / NO

• H1N1 YES / NO

Any clarifying information regarding above information _____

HEALTH EXAMINATION

Camper must be examined by a licensed physician within 24 months of camp attendance.

I have examined _____ Date Examined _____
Name of camper

In my opinion, the above camper's condition allows him/her to participate in an active camp program. (circle one): YES / NO

The camper is under the care of a physician for the following condition(s) _____

Current treatment _____

Any treatment to be continued at camp _____

Recommendations and restrictions while at camp _____

Medication(s) to be administered at camp (medication form required for each) _____

Any medically prescribed meal plan or dietary restrictions _____

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

Explanation of any reported loss of consciousness, convulsion, or concussion _____

Additional health information _____

Licensed physician's name _____ Phone _____

Address _____

Date of form completion _____ *By _____

*Physician's signature / Physician must initial if completed by nurse or physician's assistant.