Winding Trails Summer Day Camp

50 Winding Trails Drive, Farmington, CT 06032

Phone: (860) 674-4227 ext.12 Fax: (860) 676-9407

www.windingtrails.org camp@windingtrails.org

Last Name	First Name	Sex	Date of Birth

Address	Town	State	Zip Code

	Home Phone	Work Phone	Cell Phone
1st Parent			
2nd Parent			

If Parents are unavailable: Name: _____ **Phone:** _____

Health History:

____ Concussions
____ Heart Defect/Disease
____ Seizures
____ Diabetes
____ Bleeding/Clotting Disorders
____ Hypertension
____ Mononucleosis
____ Psychiatric Treatment

Diseases

____ Chicken Pox
____ Measles
____ German Measles
____ Mumps

Allergies

____ Seasonal Allergies
____ Ivy Poisoning
____ Insect Stings
____ Penicillin
____ Other Drugs
____ Asthma

Other (Specify) _____:

Has this camper been on any medication within the last six months? _____

If Yes, please explain. _____

Operations or serious injuries (dates) _____

Disability or chronic or recurring illness _____

Dietary modifications_____

Current medications (send with proper documentation _____

_____

Does you camper have permission to self administer medication Yes____No _____

If yes, please explain _____

Name of Physician_____Phone _____

Do you carry family medical insurance? Yes ____No _____

Please indicate which, if any, of the following your children may be given at camp.

Acetaminophen ____Ibuprofen _____Benadryl _____Calamine _____Throat Lozenges _____

Bacitracin ____Antacid _____Insect Repellent _____Sunscreen _____

Important - The box below must be signed & dated annually for attendance!

Authorization for Treatment: I hearby give permission to the medical personnel selected by the camp director to order x-rays, routine tests, treatment and necessary trnsportation for me or my child. In the event I cannot be reached in an emergency, I hearby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for my chold as named above. The completed forms may be photocopied for trips out of camp.

Signature of parent or guardian _____Date _____

* If for religious reasons you cannot sign this, then a legal waive must be signed for attendance.

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Health Exam Form

This form (or equivalent form) is to be completed with an exam date of within three years of attendance.

Camper Name _____ Date of Birth _____

Immunization History

Required immunizations must be determined locally. Please record the date (month and year) of basic immunization and most recent booster doses.

Vaccines	Year of Basic Immunization	Year of Last Booster
DTP		
DTP/Hib		
DTaP		
DT/Td		
OPV		
IPV		
MMR		
Measles		
Mumps		
Rubella		
HIB		
Hep B		
Varicella		
PCV		
Meningitis		

Health Care Recommendations by Licensed Physician

I have examined the above camp applicant within the past two years. **Date Examined:** _____

Please check one.

This camper ☐ may ☐ may not participate fully in the camp program.

Height _____ Weight _____ Blood Pressure _____

The applicant is under the care of a physician for the following condition(s):

_____

Current treatment (include current medications):

_____

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

_____

Does applicant have epilepsy? ☐ Yes ☐ No Does applicant have diabetes? ☐ Yes ☐ No

Recommendations and Restrictions While at Camp

Any treatment to be continued at camp:

_____

Any medications to be administered at camp (specific dosages):

_____

Any medically prescribed meal plan or dietary restrictions:

_____

Any allergies (food, drug, plants, insects, etc.):

_____

Additional Health Information:

_____

Licensed Physician's Signature _____

Address _____ Phone _____

Street & Number City State Zip Area/Number

Date of Form Completion _____ *By _____

* Initial if completed by nurse or physician's assistant