2018 CAMP ANOKIJIG HEALTH & MEDICAL FORM—MINOR VERSION

COMPLETED BY PARENT/GUARDIANS ANNUALLY

Health History: (Pages 1–3) **Physical Examination: (Page 4)**

Filled out by Parents/Guardians Each Year **Filled out by Licensed Medical Personnel**

Fill out Legibly in English

The information on this form is gathered to assist us in identifying appropriate care and adhere to state code. Health history (first 3 pages) must be filled out by the parents/guardians of minors or by adults themselves. A new Health & Medical Form is required annually (pages 1-3). Physical exams (page 4) must be completed by a licensed medical provider at least every 24 months, except every 12 months for Adventure Trips and Whitewater Day Trip participation.

DOES CAMPER NEED A NEW DOCTOR'S PHYSICAL EXAM FOR CAMP ANOKIJIG?: ☐ **YES** ☐ **NO**

If "**NO**" parent/guardian must complete pages 1 - 3 annually

If "**YES**" parent/guardian must complete pages 1 - 3 annually plus camper must get a physical examination – see page 4

Health History (Filled out by Parents/Guardians):

Camper Name: _____ DOB: _____ Age: _____
(Last, First & Middle Initial)

Home Address: _____
Street City State Zip

Custodial Parent/Guardian Name: _____

Daytime Phone: _____ Evening Phone: _____ Cell Phone: _____

Home Address: _____
(If different) Street City State Zip

Business Address: _____
Street City State Zip

If Not Available in an Emergency, Notify: _____

Relationship: _____ Phone: _____

Address: _____
Street City State Zip

Medical Insurance - Camp Anokijig does not provide camper health and/or accident insurance.
All medical/prescription bills incurred during a camp stay are the responsibility of the parent/guardian.
This camper is covered by family medical/hospital insurance ☐ Yes ☐ No

If yes; include a copy of your camper's insurance card with this form ; copy both sides of the card so information is readable.
Please indicate the name of the primary insured_____Date of birth_____

IMPORTANT: Parent/Guardian's release and authorization for treatment MUST be complete as stated.

PARENT/GUARDIAN'S RELEASE AND AUTHORIZATION FOR TREATMENT

This health history is correct and complete as far as I know. The person herein named has permission to engage in all camp activities except as noted.

Authorization for Treatment:
I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, administration of over the counter medicine, and emergency treatment for me/my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

It is my intention that the camp be treated as acting in *loco parentis* if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR § 164.510(b)) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: (i) in the case of minors, to provide relevant information to the camp representatives related to the person's ability to participate in camp activities; and (ii) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child's health status. I understand the Friends of Camp Anokijig and Camp Anokijig does not cover camper health and medical expenses.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied as needed.

Signature of parent or guardian : _____

Printed Name: _____ Date: _____

Last Name: _____ First Name: _____ MI: ____ SESSION 1 2 3 4 5 6 7 8 9

PAGES 2 & 3 COMPLETED BY PARENT/GUARDIANS ANNUALLY

Camper Name: _____

Heath History (Filled out by Parents/Guardians):

The following information must be filled in by the parent/guardian, and updated annually per state code. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

Allergies List all known. Describe reaction and management of the reaction.

Medication Allergies (list)

_____ _____

_____ _____

_____ _____

Food Allergies (list)

_____ _____

_____ _____

_____ _____

Other Allergies (list) – Include insect stings, hay fever, asthma, animal dander, etc.

_____ _____

_____ _____

_____ _____

Medications Being Taken

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the camper, the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

☐ This person takes NO medications on a routine basis.

☐ This person takes regular medications as follows (prescription medications will be given as labeled by the Doctor)

Med #1_____Dosage_____Reason for taking _____

☐ Brkfst ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other –Specify _____ _____

_____ _____

Med #2_____Dosage_____ Reason for taking _____

☐ Brkfst ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other –Specify _____ _____

_____ _____

Med #3_____Dosage_____ Reason for taking _____

☐ Brkfst ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other –Specify _____ _____

_____ _____

Attach additional pages for more medications.

Identify any medications taken during the school year that participant does/may not take during the summer: _____

_____

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)

_____

_____

Camper Name: _____

General Questions (Explain "yes" answers below)

Has/does the participant:	Yes	No
1. Had any recent injury, illness or infectious disease?	☐	☐
2. Have a chronic or recurring illness/condition?	☐	☐
3. Ever been hospitalized?	☐	☐
4. Ever had surgery?	☐	☐
5. Have frequent headaches?	☐	☐
6. Ever had a head injury?	☐	☐
7. Ever been knocked unconscious?	☐	☐
8. Wear glasses, contacts or protective eye wear?	☐	☐
9. Ever had frequent ear infections?	☐	☐
10. Ever passed out during or after exercise?	☐	☐
11. Ever been dizzy during or after exercise?	☐	☐
12. Ever had seizures?	☐	☐
13. Ever had chest pain during or after exercise?	☐	☐
14. Ever had high blood pressure?	☐	☐
15. Ever been diagnosed with a heart murmur?	☐	☐
16. Ever had back problems?	☐	☐
17. Ever had problems with joints (e.g., knees, ankles)?	☐	☐
18. Bringing an orthodontic appliance to camp?	☐	☐
19. Have any skin conditions (e.g., itching, rash, acne)?	☐	☐
20. Have diabetes?	☐	☐
21. Have asthma?	☐	☐
22. Had mononucleosis in the past 12 months?	☐	☐
23. Had problems with diarrhea/constipation?	☐	☐
24. Have problems with sleepwalking?	☐	☐
25. If female, have experienced first menstrual cycle	☐	☐
26. If female, have an abnormal menstrual history?	☐	☐
27. Have a history of bed-wetting?	☐	☐
28. Ever had an eating disorder?	☐	☐
29. Ever had emotional difficulties for which professional help was sought?	☐	☐

Please explain any "yes" answers, noting the number of the questions.

Remember to send copy of Insurance Card– both sides

_____

_____

Which of the following conditions/illnesses has the camper had?

	Year
☐ Measles	_____
☐ Chicken Pox	_____
☐ German Measles	_____
☐ Mumps	_____
☐ Hepatitis A	_____
☐ Hepatitis B	_____
☐ Hepatitis C	_____
☐ Pertussis (whooping cough)	_____

National Amer. Camp Assoc. Requirement

Required Most recent date of immunization	Month /Year
DTP (diph/tetanus/pertussis) *or*	_____
TD (tetanus/diphtheria) *or*	_____
Tetanus	_____

You may send a copy of an immunization record from school , athletics or the state web site in place of the vaccination information above.

Which of the following has your camper been vacinated for?

	Yes
Measles	☐
Chicken Pox	☐
German Measles	☐
Mumps	☐
Hepatitis A	☐
Hepatitis B	☐
Pertussis (whooping cough)	☐

I have chosen to NOT immunize my child and will send to the Camp Office a signed and dated statement saying so prior to my child's arrival at Camp Anokijig. ☐

My child is up-to-date on all immunizations Yes ☐

Description of any current physical, mental, or psychological conditions requiring medication, treatment, or special restrictions or considerations while at camp? Please explain in detail.

_____

_____

_____

Camper Name: _____

Camper exams should be within 24 months of last date of camp attendance to be filled out by a licensed M.D., R.N., or Equivalent. Each camper must have a physical exam on file in order to attend camp. Adventure Trips and Whitewater Day Trip require exam within 12 months of last date of camp attendance.

PAGE 4 COMPLETED BY LICENSED MEDICAL PERSONNEL

Physical Examination by Licensed Medical Personnel

Fill out Legibly in English

Date of Exam: _____.

BP _____ Weight _____ Height _____

In my opinion, the above applicant: ☐ is able to participate in active camp program activities with no restrictions

☐ is able to participate in an active camp program with the restrictions indicated below.

The applicant is under the care of a physician for the following conditions

_____

_____

_____

Recommendations and Restrictions at Camp

Treatment to be continued at camp _____

_____

Medications to be administered at camp (name, dosage, frequency) _____

_____

Any medically-prescribed meal plan or dietary restrictions _____

_____

Known allergies _____

_____

Description of any limitation or restriction on camp activities _____

_____

Additional information for health care staff at the camp _____

_____

Signature of Licensed Medical Personnel _____

Printed _____ Title _____

Address _____

Phone _____ Date_____

Mailing Address:
Camp Anokijig
W5639 Anokijig Lane
Plymouth, WI 53073
920-893-0782
800-741-6931
anokijig@anokijig.net