Camp Wabanna

Camper Health Form

Mail this form to the address below
Camp Wabanna
101 Likes Road
Edgewater, MD 21037

Camper Name: _____
First Middle Last

Male Female Birth Date _____ Age on arrival at camp: _____

Please circle the session(s) your camper is attending: Day Camp Residential Camp
Week 1 Week 2 Week 3 Week 4 Week 5 Week 6 Week 7 Week 8 Week 9

To Parent(s)/Guardian(s): Please follow the instructions below. Attach additional information if needed.

*1) **Complete pages 1 and 2 of this form and make a copy.***

*2) **Send the original CAMPER HEALTH FORM to camp by the requested date.***

Camper Home Address: _____
Street Address City State Zip Code

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name: _____ Relationship to Camper: _____ Preferred Phones: (_____)_____(_____)_____

Second parent/guardian contact:

Name: _____ Relationship to Camper: _____ Preferred Phones: (_____)_____(_____)_____

Two additional contacts in event parent(s)/guardian(s) cannot be reached:

1)Name(s): _____ Relationship to Camper: _____ Preferred Phones: (_____)_____(_____)_____

2) Name(s): _____ Relationship to Camper: _____ Preferred Phones: (_____)_____(_____)_____

Health-Care Providers:
Name of camper's primary doctor: _____ Phone: (_____) _____

Allergies: No known allergies. This camper is allergic to: Food Medicine The environment (insect stings, hay fever, etc.) Other
(Please describe below what the camper is allergic to and the reaction seen.)

Immunization History: Provide the month and year for each immunization. Starred (★) immunizations must be current. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diptheria, tetanus, pertussis★ (DTaP) or (TdaP)						
Tetanus booster★ (dT) or (TdaP)						
Mumps, measles, rubella★ (MMR)						
Polio★ (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B .						
Hepatitis A .						
Varicella (chicken pox) Had chicken pox Date:						
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test Date: Negative Positive

If your camper has not been fully immunized, please sign the following statement: **I understand and accept the risk to my child from not being fully immunized.**

Signature of Custodial Parent/Gaurdian:_____ Date:_____ Relationship to camper:_____

Medication: This camper will not take any daily medications while attending camp.

This camper will take the following daily medication(s) while at camp:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. ***Please review camp instructions about required packaging/containers. Maryland requires original pharmacy containers with labels which show the camper's name and how the medication should be given. Provide enough of each medication to last the entire time the camper will be at camp.***

Name of Medication	Date started	Reason for taking it	When it is given	Amount or dose given	How it is given
			oBreakfast oLunch oDinner oBedtime oOther time:		
			oBreakfast oLunch oDinner oBedtime oOther time:		
			oBreakfast oLunch oDinner oBedtime oOther time:		

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. ***Cross out those the camper should not be given.***

Acetaminophen (Tylenol)
Phenylephrine decongestant (Sudafed PE)
Antihistamine/allergy medicine
Diphenhydramine antihistamine/allergy medicine (Benadryl)
Sore throat spray
Calamine lotion
Laxatives for constipation (Ex-Lax)
Ibuprofen (Advil, Motrin)
Pseudoephedrine decongestant (Sudafed)
Guaifenesin cough syrup (Robitussin)
Dextromethorphan cough syrup (Robitussin DM)
Generic cough drops
Aloe
Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)

General Health History: *Check "Yes" or "No" for each statement. Explain "Yes" answers below.*

Has/does the camper:

1. Passed out/had chest pain during exercise?.....	Yes	No	6. Had seizures?	Yes	No
2. Had a recent infectious disease?	Yes	No	7. Have any skin problems?.....	Yes	No
3. Had a recent injury?	Yes	No	8. Have problems with falling asleep/sleepwalking?	Yes	No
4. Had asthma/wheezing/shortness of breath?.....	Yes	No	9. Have problems with diarrhea/constipation?.....	Yes	No
5. Have diabetes?	Yes	No	10. Wear glasses, contacts, or protective eyewear?.....	Yes	No

Please explain "Yes" answers in the space below, noting the number of the questions.

Mental, Emotional, and Social Health: *Check "Yes" or "No" for each statement.*

Has the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?	Yes	No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?.....	Yes	No
3. During the past 12 months, seen a professional to address mental/emotional health concerns?.....	Yes	No

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

What Have We Forgotten to Ask? *Please provide in the space below* any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program***. Attach additional information if needed.***

TO THE BEST OF MY KNOWLEDGE, THE INFORMATION GIVEN ON THESE TWO PAGES IS COMPLETE AND ACCURATE.

Signature of Parent/Guardian _____ Date_____