



**Camp Wabanna**  
**Camper**  
**Health/Consent Form**

Mail this form to the address below by June 1st  
**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

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

- 1) Complete all 4 pages of this form and make a copy.
- 2) Send the original CAMPER HEALTH FORM to camp by June 1<sup>st</sup>.

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 Phone: (\_\_\_\_\_) \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_ Preferred Phone: (\_\_\_\_\_) \_\_\_\_\_

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

1) Name(s): \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_ Preferred Phone: (\_\_\_\_\_) \_\_\_\_\_

2) Name(s): \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_ Preferred Phone: (\_\_\_\_\_) \_\_\_\_\_

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
Diphtheria, 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 Had chicken pox (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.***

Parent/Guardian: \_\_\_\_\_ 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)                                   | Ibuprofen (Advil, Motrin)                                     |
| Phenylephrine decongestant (Sudafed PE)                   | Pseudoephedrine decongestant (Sudafed)                        |
| Antihistamine/allergy medicine                            | Guaifenesin cough syrup (Robitussin)                          |
| Diphenhydramine antihistamine/allergy medicine (Benadryl) | Dextromethorphan cough syrup (Robitussin DM)                  |
| Sore throat spray   | Generic cough drops   |
| Calamine lotion   | Aloe  |
| Laxatives for constipation (Ex-Lax)                       | 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:

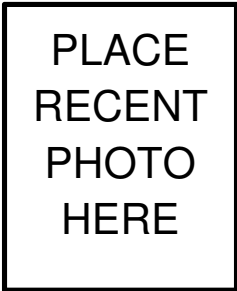
- |  |     |    |
|--|-----|----|
| 1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? ..... | Yes | No |
| 2. Ever been treated for emotional or behavioral difficulties or an eating disorder?.....                            | Yes | No |
| 3. 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.*****



Please read and sign the following consent form:



WHEREAS, certain circumstances and situations may occur resulting in my child's need for medical/dental care and treatment, and further resulting in my inability to give personal consent for such care and treatment,

THEREFORE,

1. In consideration of permission for my child to participate in said camp program, I, \_\_\_\_\_, being of legal age, authorize Camp Wabanna or any agent of Wabanna Bible Conference, Inc. to act in my child's behalf should I be unable to do so and to consent to reasonable medical/dental care and treatment, including but not limited to diagnostic tests, x-ray examination, anesthesia, surgery, or any other procedures which may be deemed necessary for my child's medical well-being for the duration of the camp stay.
2. I recognize that this consent is given in advance of any specific diagnosis, treatment, surgery, hospital care, or any other procedure required, but is necessary to provide authorization and specific consent for medical/dental treatment and care in my child's behalf due to the nature and destination of the program.
3. Any consent by Camp Wabanna, or any agent of Wabanna Bible Conference, Inc., shall have the same force and effect as if I had personally signed the consent.
4. I certify that I have personal health insurance with:

\_\_\_\_\_  
Company

\_\_\_\_\_  
Policy Number

with no territorial limitations, which will provide coverage for my child during the duration of said program. I understand that no health plan is provided through Camp Wabanna, and any expenses resulting from medical treatment of \_\_\_\_\_ are my sole responsibility. Should Camp Wabanna incur any expenses for the medical treatment of my child, I shall reimburse Camp Wabanna within 30 days of receiving the bill from Camp Wabanna.

5. I am aware that serious illness requiring transportation by ambulance can be quite costly and that coverage for this type of service is not covered by any health plan available through Camp Wabanna. I agree that I am responsible for any expenses that may arise from my child's transportation by ambulance or other extraordinary means.

6. I hereby release and hold harmless Wabanna Bible Conference, Inc. and their officers, and employees from all liability for bodily personal injury, arising as a result of medical/dental treatment given pursuant to this prior consent.

7. By signing below, I acknowledge and accept the risks of physical injury associated with participation in the camp program and field trips. Except for gross negligence on the part of the camp, I accept personal financial responsibility for any bodily or personal injury sustained during the camp program or field trips. Further, I promise to release and hold harmless Wabanna Bible Conference, Inc. and its representatives for any injury related to the activity. I recognize that certain hazards and dangers are

inherent in camp events and programs. And particularly but not limited to, swimming, boating, field activities, ropes courses, team courses, tower climbing, water tubing, canoeing. I understand that adventure activities may expose my child to psychologically and physically stressful and challenging situations. I understand, too, that although the program has taken precautions to provide proper organization, supervision, instruction, and equipment for each activity, it is impossible for the program to guarantee absolute safety. I understand that my child shares responsibility for his/her safety and I have instructed my child in the importance of knowing and abiding by the camp rules, regulations, and procedures for his/ her safety of camp participant.

8. By signing below, I acknowledge and accept that Camp Wabanna reserves the right to discipline or send home any child for any reason in its sole discretion. General reasons for immediate dismissal include, but are not limited to any of the following: or if a child is defiant, uncooperative, and will not or cannot participate in the normal program. Campers sent home due to behavioral problems are not allowed to return. No refund will be given if a child is sent home for behavioral reasons. If a departure need arises, parents/guardians or emergency contacts will be notified. Upon notification, the parent/guardian will be allowed a maximum time of four hours to remove their child from camp property.

9. By signing below, I acknowledge and accept that Camp Wabanna reserves the right to send home any child if a health situation puts another individual in jeopardy, if the camper needs special health attention, if a child has a temperature above 101 degrees, pink eye, ring worm, lice, strep throat, or any infectious situation; Campers sent home due to medical reasons can only return to camp with a doctor's release and must be able to participate in the normal camp program. No refund will be given if a child is sent home for medical reasons. If a departure need arises, parents/guardians or emergency contacts will be notified. Upon notification, the parent/guardian will be allowed a maximum time of four hours to remove their child from camp property.

10. By signing below, I acknowledge and accept Camp Wabanna's cancellation policy. That cancellation for any reason before June 1<sup>st</sup> forfeits \$150. There are no refunds for cancellation for any reason after June 1<sup>st</sup>.

11. By signing below, I acknowledge and give permission for the use of photographs, or other media, including my son or daughter to be used in camp publicity.

If a dispute over this agreement or any claim for damages arises, I agree to resolve the matter through a mutually acceptable arbitration process.

I HAVE READ ALL THE AFOREMENTIONED INFORMATION AND I AGREE TO COOPERATE AND ADHERE TO THESE GUIDELINES. TO THE BEST OF MY KNOWLEDGE, THE INFORMATION GIVEN ON THESE TWO PAGES IS COMPLETE AND ACCURATE.

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Signature of Parent/Guardian

Date