**WOODLAKE VILLAGE DAY CAMP MEDICAL FORM This form must be returned before the start of camp**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  | **(***To be completed by the parent***)** |  |  |  |
| **COMING:** | FIRST NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ LAST NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_/\_\_\_\_/\_\_\_\_\_ | IN EMERGENCY CALL: |  |
| NAME: |  |
|  |  |  |  |  |  |  |
| o | **July** | STREET ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CHILD’S SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| o | **August** | CITY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE\_\_\_\_\_\_\_ ZIP\_\_\_\_\_\_\_\_\_\_PHONE # (\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_ | RELATIONSHIP: |  |
|  |  |  |  |  |  |  |
| CELL PHONE (\_\_\_\_\_) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_ WORK PHONE (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
|  |  |  |  |
|  |  | FAMILY PHYSICIAN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | PHONE (\_\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ | PHONE #: |  |
|  |  | (\_\_\_\_\_)\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_ |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  | *(To be Completed by Examining Physician)* |  |  |  |
|  |  | **Immunizations:** |  |  |  | **Physical Exam** |  |  |
| **Immunization Type** |  | **Date Basic Series Completed** | **Most Recent Booster** |  |  |  |  |  |
|  |  |  | Code: S- Satisfactory | X-Not Satisfactory (explain) |  |
| DPT/ DT |  |  |  |  |  |  |
|  |  |  |  | B.P. |  |  |  | Hgb. Test Done: |  |  |  |
| Tetanus |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  | Urinalysis Test Done: |  |  |  |  |
| MMR 1 |  |  |  |  |  |  |  |  |  |
|  |  |  |  | Height |  |  |  |  |  | Heart |  |  |  |
| MMR 2 |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  | Weight |  |  |  |  |  | Lungs |  |  |  |
| HIB |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  | Eyes |  |  |  |  |  | Abdomen |  |  |  |
| OPV / IPV |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  | Glasses |  |  |  | Genitalia |  |  |  |
| Hepatitis A |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  | Ears |  |  |  |  |  | Hernia |  |  |  |
| Hepatitis B |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  | Nose |  |  |  |  |  | Extremities |  |  |  |
| Tine Test |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  | Throat |  |  |  |  |  | Posture (Spine) |  |  |
| Varicella |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  | Teeth |  |  |  |  |  | Skin |  |  |  |
| Meningococcal |  |  |  |  |  |  |  |  |  |  |  |  |



Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergic Reactions (bee stings, penicillin, etc…) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recommendations and Restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medical Conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications to be continued at Camp (name, strength & dosage): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like us to be aware of anything to assist us in caring for your child? (frequent colds, ear infections, sore throats, stomach problems, diarrhea, nausea, vomiting, constipation, insect bites, sleep walking, etc….)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**PLEASE**

**SIGN**

|  |  |  |  |
| --- | --- | --- | --- |
| I have examined the above patient. | Date Examined: \_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| In my opinion his/her condition **does\_\_\_\_/ does not\_\_\_\_** allow participation in an active camp program. |  |  |
| Exceptions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
|  |  |  |

**Physician’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_ Phone #: (\_\_\_)\_\_\_\_-\_\_\_\_\_\_\_\_**

**Insurance Information**

Parents: Please fill out your insurance information below:

Medical Insurance Carrier\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy/ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE PASTE AND/OR STAPLE A COPY OF YOUR INSURANCE/ PRESCRIPTION

CARD IN THE DESIGNATED BOX BELOW



|  |  |
| --- | --- |
| **Please paste / staple a** | **Please paste / staple a** |
| **COPY of the FRONT of your** | **COPY of the FRONT of your** |
| **INSURANCE Card** | **PRESCRIPTION Card** |
|  | **(if different)** |

|  |  |
| --- | --- |
| **Please paste / staple a** | **Please paste / staple a** |
| **COPY of the BACK of your** | **COPY of the BACK of your** |
| **INSURANCE Card** | **PRESCRIPTION Card** |
|  | **(if different)** |



**If your child receives any medical treatment whatsoever during the summer, Woodlake Day Camp will utilize the attached insurance/ prescription cards. In the unlikely event that the pharmacy/doctor does not accept your medical/prescription card, I hereby authorize Woodlake Day Camp to use the following credit card for purposes of paying for such charges.**

**Name on Card:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Discover | Visa | MasterCard (Circle one)**

**Card Number:\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_ Expiration Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent’s Authorization**

It is our firm hope that the authorization below will never have to be used. In an emergency, however, where immediate treatment is required before a parent can be contacted, this form can be extremely important. Without it, many doctors and hospitals will refuse to treat a minor as a matter of sound medical practice. Therefore, Camp requires this authorization to be signed by a parent for every camper and staff member.

In case of emergency, I, (please print name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

hereby authorize the doctor or the hospital to which my child,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_,

may be brought, (and whomever they may designate as their assistants) to perform any emergency procedure or operation, to give treatment, injections and the administration of an anesthetic to my child.

Signature of Parent or Guardian

Date

\*\*\*IMPORTANT: The Camp office must be notified if your child is exposed to any communicable disease during the *three weeks prior* to Camp attendance. \*\*\*