



CAMPER HEALTH FORM

Name of camper _____ Date of Birth _____

Blood Pressure _____ Weight _____ Height _____

DATE OF LAST FULL PHYSICAL _____

MEDICAL HISTORY (X for positive findings)

Allergies:

Contact () _____

Food () _____

Insect () _____

Pollens () _____

Needs EpiPen () _____

Seizures () _____

Fractures () _____

Heart problems () _____

Headaches () _____

Joint disease () _____

Asthma - uses inhaler () _____

Stomach problems () _____

ADD/ADHD () _____

Ear problems () _____

MEDICINES TAKEN REGULARLY

MEDICINES ALLERGIC TO:

Penicillin: Yes () No ()

Others: _____

IMMUNIZATIONS

***** PLEASE ENCLOSE COPY OF CURRENT IMMUNIZATION RECORD!

Your signature below authorizes the camp nurse to dispense the following over-the-counter medications:

Acetaminophen/Tylenol

Calagel

Medicine Stingese

Ibuprofen/Advil

CortAid .5% crème

Hall's coughdrops

Benadryl (liquid and tablet) Bacitracin Isotonic eye irrigating solution

Signature _____

IF YOUR SON IS TO RECEIVE PRESCRIPTION MEDICATIONS, USES AN INHALER, OR NEEDS AN EPIPEN, PLEASE ENCLOSE A WRITTEN ORDER FROM YOUR PHYSICIAN AND SEND THE MEDICATIONS IN THE ORIGINAL PHARMACY-LABELLED CONTAINER. NO PRESCRIPTION MEDICATIONS WILL BE DISPENSED UNLESS THEY ARE IN A PHARMACY-LABELLED CONTAINER AND UNLESS WE HAVE A WRITTEN ORDER FROM A PHYSICIAN.

Please continue to page 2.

EMERGENCY INFORMATION

Names of parents (including first names) _____

Home address (es) _____

Home phone (s) _____

Cell(s) _____

Father's employer _____

E-mail Address _____

Business phone _____

Mother's employer _____

E-mail Address _____

Business phone _____

Persons to call in an emergency if you cannot be reached:

Name _____ Phone _____

Name _____ Phone _____

Name of camper's doctor _____

Phone _____

MEDICAL INSURANCE COMPANY _____

CERTIFICATE # _____ CODE _____

***** We also need to have copies of the insurance and prescription cards.

***** I hereby give my permission to Stefanie Wilbur RN, Phillip Williams, or other Camp Wachusett personnel in charge to take necessary medical action in emergency situations for my child when I am not immediately available.

Signature _____

Soc. Sec. # _____

Camper's Soc. Sec. # (if available) _____

Date _____

Mail to:
Camp Wachusett
P.O. Box 33
Irvington, VA 22480

After June 15 Mail to:
Camp Wachusett
1430 Camp Road
Brandon, VT 05733

Or scan and email to:
director@campwachusett.com