FARM & WILDERNESS HEALTH HISTORY FORM

DUE JUNE 1

The information on this form is integral to your camper's enrollment. F&W policy requires a physical exam be completed by a provider within 12 months of the start date of camp. **All parts of this form must be completed each year and submitted before your child's arrival at camp**. Please submit this form as early as possible to ensure our medical team has permission to treat and care for your camper. Please **include this form, a completed and signed copy of a physical exam, immunizations records, and copies of insurance card(s).**

CAMP ________________________________ **SESSION ATTENDING**______________________________

Camper Name ____ Birth Date _____/_____/_____
Last *First* *Middle*

Age on July 1________ Social Security # ______-____-______ ☐ New camper ☐ Returning camper

Home Address____
Street Address *City* *State* *Zip*

EMERGENCY CONTACT

Custodial Parent/Guardian ____________________________________ Email address __________________________

Primary Phone (______) ________________________Secondary Phone (______) ______________

Address *(if different than above)* ____
Street Address *City* *State* *Zip*

Second Parent/Emergency Contact ____ Phone (______) ___________________

Name of camper's Primary Care Provider ____ Phone (______) ______________

INSURANCE INFORMATION PLEASE FILL OUT COMPLETELY

Is the camper covered by medical insurance? ☐No ☐ Yes *If yes, please complete the following.* ***You MUST attach a copy of the front and back of the insurance card****. Also attach a copy of the prescription (Rx) card if it is a separate card.*

Subscriber Name ____ Relation to camper ___________________________

Subscriber Birth Date _____/_____/_____ Subscriber Social Security # ______-____-______

Insurance Company Name ____ Phone (______) _____________________

Insurance Company Address ____
Street Address *City* *State* *Zip*

Policy # ____________________________ Group # ___________________________ ID # _____________________

Pharmacy Group ID ________________ Rx PCN# ________________ Rx BIN# ________________ Rx ID________________

PARENT/GUARDIAN AUTHORIZATION (REQUIRED)

I certify that this health form is complete and true to my best knowledge. The camper above has permission to engage in all camp activities except as noted as restrictions or on the physical exam. I hereby give permission to the camp health staff to provide, seek, or consent to routine health care, to administer prescribed and over-the-counter medications, and seek medical treatment as needed, including by not limited to primary care office visits, x-rays, laboratory studies, specialty appointments, Emergency Room visits, and/or hospitalization. I hereby give permission to the camp to arrange related transportation. I agree to the release of any medical records necessary for treatment, referral, billing, or insurance purposes.

In the event that I cannot be reached in an emergency, I hereby give permission to Farm & Wilderness medical team to secure and administer treatment, including hospitalization, for the person named above. It is also my intention that the appropriate personnel of the camp be treated as my "personal representatives" for the purposes of disclosing protected health information. I hereby agree to the disclosure, by health care providers to camp representatives, of protected health information of the person named above as necessary to 1) provide relevant information related to the camper's ability to participate in camp activities and 2) to provide relevant information to camp representatives as to keep me informed of my child's health status. I understand that this form may be photocopied.

Signature of Parent/Guardian ____ Date _____/_____/_____

Printed Name ______________________________________ Relationship to camper ______________________________

DUE JUNE 1

HEALTH HISTORY

Does the camper have any current, ongoing, or chronic health conditions? ☐ No ☐ Yes *If yes, please explain* ___________________________

____

Please check yes if the camper has ever been diagnosed or treated for the following and no if not. Explain all yes answers in space provided.

	YES	NO		YES	NO
1) Hospitalized overnight?	☐	☐	11) Heart condition/murmur?	☐	☐
2) Surgery?	☐	☐	12) Headaches/migraines?	☐	☐
3) Recent contagious illness?	☐	☐	13) Skin problems?	☐	☐
4) Recent injury?	☐	☐	14) Problems with sleep/sleepwalking?	☐	☐
5) Asthma/wheezing?	☐	☐	15) Problems with bedwetting?	☐	☐
6) Seizures?	☐	☐	16) ADD/ADHD?	☐	☐
7) Digestion/intestinal problems?	☐	☐	17) Anxiety/depression?	☐	☐
8) Chest pain with activity?	☐	☐	18) Immune disorder?	☐	☐
9) Passed out with activity?	☐	☐	19) Eating disorder?	☐	☐
10) Bone/joint injuries?	☐	☐	20) Prone to severe homesickness?	☐	☐

Please explain all "yes" answers ____

____

MENTAL HEALTH

Has the camper ever been diagnosed/treated for a mental health issue? ☐ No ☐ Yes *If yes, please explain* ___________________________

____

____

MEDICATIONS

Is the camper currently taking any medications (prescription, over-the-counter, herbal, homeopathic, or alternative)? ☐ No ☐ Yes

Medication Name and Dose (mg)	**Time(s) Taken**	**How it is given**	**Reason for use**

RESTRICTIONS

I have reviewed the activities at camp, and feel that the camper can ☐ Participate fully

☐ Participate with the following restrictions and/or adaptations due to health concerns: ___________________________

____

____

ALLERGIES

☐ No known allergies ☐ This camper is allergic to: ___________________________

Please describe reaction that occurs ____

____

How is the allergy treated?____

____

DIET/NUTRITION

☐ This camper eats a regular diet. ☐ This camper eats a regular vegetarian diet.

☐ This camper has special food needs *please describe here* ____

____

____

FARM & WILDERNESS
263 Farm &Wilderness Rd
Plymouth, VT 05056
(802) 422-3761

THIS FORM SHOULD BE COMPLETED AND SIGNED BY THE CAMPER'S PRIMARY CARE PROVIDER AND CAN BE RETURNED SEPARATELY. ALTERNATIVELY, A COPY OF A PHYSICAL EXAM AND IMMUNIZATION RECORD CAN BE SENT TO CAMP *AHEAD OF THE CAMPER'S ARRIVAL.*

HEALTH EXAM FORM

Camper Name ______________________________ Birth Date _____/_____/_____

Name of camper's Primary Care Provider ______________________________ Phone (______) ____________________

Clinic Address ____
Street Address *City* *State* *Zip*

Date of most recent physical exam _____/_____/_____

Weight ___________ Height ___________ Blood Pressure _________/__________

ALLERGIES

Does the camper have any known allergies? ☐ None known ☐ Known allergies *Please describe allergy, reaction, and treatment*

____

____

HEALTH CONDITIONS

Is the camper being treated or followed for any medical or mental health condition(s)? ☐ None ☐ The following *Please describe*

____

____

MEDICATIONS

Should the camper continue any medications while at camp? ☐ None ☐ The following *Name, dose, route, timing, duration*

____

____

ACTIVITY RESTRICTIONS

Should the camper have any limitations or adaptations in activity while at camp? ☐ None ☐ The following *Please describe*

____

____

IMMUNIZATIONS

Please fill out the following immunization record, or attach a copy of immunization record

Immunization	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
Tetanus (DTap, TDaP)	_____/_____	_____/_____	_____/_____	_____/_____	_____/_____
Tetanus Booster (Td)	_____/_____				
MMR	_____/_____	_____/_____			
Hepatitis A	_____/_____	_____/_____			
Hepatitis B	_____/_____	_____/_____			
HIB	_____/_____	_____/_____	_____/_____	_____/_____	
Polio (IPV)	_____/_____	_____/_____	_____/_____	_____/_____	
Meningitis (Menactra)	_____/_____	_____/_____			
Chicken Pox (Varicella)	_____/_____	_____/_____	If had disease, check box ☐		
Influenza	_____/_____	_____/_____			
TB Test (Mantoux skin)	_____/_____	Result: ☐ Neg ☐ Pos			

Immunization exemption

☐ Please check box if the camper has not received childhood immunizations for religious/personal/medical reasons.

SIGNATURE OF LICENSED PRIMARY CARE PROVIDER ____________________________ Date ____/____/____