Camp Winnarainbow

Session(s) attending:_____

Please fill out completely, SIGN and return these forms to the address below.

CAMPER INFORMATION SHEET for Camper Name: _____

Section I of this form is to be filled out by Camper. Section II to be completed by parent/guardian. We will share this information with the Camper's counselor so they will know your Camper a little better before they arrive at Camp. Use another sheet of paper if you need more room. Please return this form with the medical forms to our Camp Office no less than two weeks before your Camper's session is scheduled to begin.

If you wish to inform us of something you consider extremely confidential, please include a separate note and mark it "confidential". We may share this information with some members of the Camp staff only on a "need-to-know" basis, but they will understand it is to be kept in confidence, and we will safeguard your note in our office.

SECTION I: TO BE COMPLETED BY CAMPER

1. If you will have a birthday at Camp, what is the date? _____
2. Have you been to Camp Winnarainbow before? _____

   Have you ever been to another overnight camp? _____

   If so, how long was it? _____ What did you like best about it? _____

   What didn't you like about it? _____
3. What are your favorite things to do? Do you have any hobbies or interests? _____

   _____
4. How do you feel about coming to Camp Winnarainbow? _____

   What are you looking forward to doing at Camp? _____

   _____

   Is there anything about coming to Camp that you are worried about? _____

   _____
5. Do you think you will feel a little homesick? _____

   If so, what can your counselor do to help you? _____

   _____
6. Is there anything you would like to tell your counselor before you arrive? _____

   _____

SECTION II: TO BE COMPLETED BY PARENT / GUARDIAN

1. Do you have any concerns about your child attending Camp? _____

   _____

   Do you have suggestions for the counselor to help your child? _____

   _____
2. Are there any behaviors or special circumstances about which you would like your child's counselor to be aware and/or sensitive? (ex: bedwetting, sleepwalking, nightmares, recent divorce or death, fears, etc.) _____

   _____
3. Are there any activities / classes in which you do NOT wish your Camper to participate? _____

   _____
4. **Name of authorized person picking up Camper on last day of Camp? _____**

   Relation to Camper _____ Home Phone_____ Cell Phone _____

5. Form signed by _____ Print Name _____ Relationship _____

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Camp Winnarainbow

Session(s) attending _____

Please fill out completely, SIGN & return BOTH copies of these forms to the address below.
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CAMP WINNARAINBOW HEALTH HISTORY FORM: PAGE 1 OF 4 (To be completed by Parent / Guardian)

The information on this form is not part of the camper acceptance process and is gathered to assist us in identifying appropriate care. The "Health History Form" must be filled out by parent / guardian of minor. Updates are required annually. All information is maintained in a strictly confidential manner.

CONTACT INFORMATION

Camper Name _____ Birth Date_____/_____/_____ Age _____Gender _____
(Last, First) (First Day of Camp)

Home Address_____
(Number and Street, Apt, City, State, Zip)

Parent 1 / Guardian _____ Home Phone_____
(Name) (Area Code / Number)

Address _____ Cell Phone_____
(If different from above) (Number, Street, City, State, Zip) (Area Code / Number)

Work Phone_____
(Area Code / Number)

Parent 2 / Guardian _____ Home Phone_____
(Name) (Area Code / Number)

Address _____Cell phone _____
(If different from above) (Number, Street, City, State, Zip) (Area Code / Number)

Work Phone_____
(Area Code / Number)

Alternate Emergency Contact _____ Hm #_____ Alt #_____
(Name) (Area Code / Number) (Area Code / Number)

INSURANCE INFORMATION - Please attach a photocopy of both front/back of insurance card(s) to this form.

Is camper covered by family medical or hospital insurance? □YES___ NO____ MediCal / Healthy Families _____

Carrier Name _____ Group # _____ Policy/MR # _____

Carrier Address _____ Phone _____

Family Doctor _____ Dentist _____
(Name, Phone) (Name, Phone)

****

IMPORTANT - The boxes below MUST be completed for attendance

This health history is correct and complete to the best of my knowledge. The person named herein has permission to engage in all Camp activities, except as noted.
I give permission for Camp Winnarainbow to provide routine health care, administration of prescribed medications and emergency treatment for my child as may be necessary, including but not limited to, x-rays, routine tests and treatment and/or hospitalization. I also give permission for Camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.
I give permission for Camp Winnarainbow (CWR) and its representatives to act *in loco parentis* of above named minor, including designation of CWR personnel to act as "personal representatives" for the purpose of disclosing protected health information pursuant to the privacy regulations outlined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I agree [as defined in section 45CFR §164.510(b)] to the disclosure by Camp representatives of the protected health information of above-named person: (i) to provide relevant information to the Camp representatives related to the person's ability to participate in Camp activities, and (ii) to provide relevant information to Camp representatives to keep me informed of the status of my child's health.
In the event I cannot be reached in an emergency, I hereby give permission to the Health Care Professional(s) selected by CWR to secure and administer appropriate treatment, including hospitalization, for the person named above. I understand that I am financially responsible for any treatments this child receives while at Camp Winnarainbow. This completed form may be photocopied.

Signature of Parent or Legal Guardian _____

Printed Name _____ Date _____

I understand and agree to abide by any restrictions placed on my participation in Camp activities.

Signature of Minor Camper _____ Date _____

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Camp Winnarainbow

Session(s) attending _____

Please fill out completely, SIGN & return **both** copies of these forms to the address below. These are duplicate copies. Do Not Stack. Use ballpoint pen firmly.

Camper's Name _____

CAMP WINNARAINBOW HEALTH HISTORY FORM: PAGE 2 OF 4 (To be completed by Parent / Guardian)

SECTION I: ALLERGIES

_____ **Initial here if camper has NO known allergies. (Skip to section II.)**

List All Known Allergies. Describe reaction and management of reaction.

A) Medication Allergies

_____

_____

B) Food Allergies

_____

_____

C) Other Allergies (Include insect stings, hay fever, asthma, animal dander, etc.)

_____

_____

SECTION II: MEDICATIONS BEING TAKEN

_____ **Initial here if this camper takes NO prescription medications on a routine basis.**

Please list ALL medications routinely taken here. Bring/send enough medication for the camper's entire stay at Camp. Be sure to send any medications to Camp in the ORIGINAL PHARMACY packaging / bottle that identifies prescribing physician (if prescription drug), name of medication, dosage and frequency of administration. Please also send any equipment necessary for medication administration including spacers for inhalers, peak flow meters, etc.

Med #1 _____ Dosage _____ Specific times to be taken daily _____

Purpose for medication _____

Med #2 _____ Dosage _____ Specific times to be taken daily _____

Purpose for medication _____

Please attach additional pages for more medications.

List below any non-prescription medications / vitamins to be taken or administered while at camp:
(Please do not send common medications like aspirin, ibuprofen, etc. to camp. Our infirmary stocks common over-the-counter medications for dispensation by the Camp medical staff.)

_____

List below any medications taken during the school year that your camper does **not** take in the summer:

_____

SECTION III: RESTRICTIONS

_____ **Initial here if camper has NO restrictions on diet or activities. (Skip to Section IV.)**

Dietary Restrictions (Check any that apply.)

[ ] Does not eat "red" meat [ ] Does not eat pork [ ] Does not eat poultry [ ] Does not eat eggs
[ ] Does not eat fish [ ] Does not eat shellfish [ ] Does not eat dairy products
[ ] Does not eat _____ (specify)

Activity Restrictions

Explain any restrictions on activities. Identify any limitations or adaptations that may be necessary.

_____

Camp Winnarainbow

Session(s) attending _____

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Camper's Name _____

CAMP WINNARAINBOW HEALTH HISTORY FORM: PAGE 3 OF 4 (To be completed by Parent / Guardian)

SECTION IV: IMMUNIZATION HISTORY

New to Camp: Please attach a copy of current immunization record to this form

Returning Camper: Initial here if child is **current** on all immunizations and you've provided records to Camp in previous years: _____

SECTION V: HEALTH HISTORY - General Questions

Has/ Does the Camper:

Y N Ever had seizures?
Y N Had any recent injury, illness or infectious disease?
Y N Have a chronic or recurring illness or condition?
Y N Ever been hospitalized?
Y N Ever had surgery?
Y N Have frequent headaches?
Y N Ever had a head injury?
Y N Ever been rendered unconscious?
Y N Wear glasses, contacts or protective eyewear?
Y N Ever had frequent ear infections?
Y N Ever lost consciousness during or after exercise?
Y N Ever been dizzy during or after exercise?
Y N Ever had chest pain during or after exercise?
Y N Ever had high blood pressure?
Y N Ever been diagnosed with a heart murmur?
Y N Ever had back problems?
Y N Ever had problems with joints? (e.g. knees, ankles)
Y N Have an orthodontic appliance to be brought to Camp?
Y N Have any skin problems? (e.g. itching, rash, acne)
Y N Ever had emotional difficulties for which professional help was sought?
Y N Received a tetanus booster? Date: _____

Y N Have asthma?
Y N Have problems with sleep-walking?
Y N Have a history of bed-wetting?
Y N Had mononucleosis in the past 12 months?
Y N Had problems with diarrhea/ constipation?
Y N Commenced her menstrual period?
Y N Ever had an eating disorder?

Had any of the following diseases?

Y N Measles
Y N Chicken Pox
Y N German Measles
Y N Mumps
Y N Hepatitis A
Y N Hepatitis B
Y N Hepatitis C
Y N Diabetes

Y N Have any other condition(s) not mentioned here? _____

Please explain and date any "Yes" answers below.

_____

_____

Please describe any additional information about your camper's emotional, behavioral, physical or mental health that may be of significance in attending Camp Winnarainbow's program.

_____

_____

_____

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CAMP WINNARAINBOW HEALTH HISTORY FORM: PAGE 4 OF 4

SECTION VI: To be completed by Parent / Guardian

Camper Name _____ Birth Date____/____/____ Gender _____
(Last, First)

Parent / Guardian _____ Home Phone_____
(Name) (Area Code / Number)

Address _____Cell Phone_____
(Number Street City State Zip) (Area Code / Number)

Custodian gives permission to share medical information with Camp Winnarainbow via this form. **Initial:** _____

SECTION VII: TO BE COMPLETED BY LICENSED HEALTH CARE PROFESSIONAL (LHCP)

I have examined this child within the past two years. LHCP- Print Name _____

BP _____ Weight _____ Height _____ Date examined _____

In my opinion, the above applicant is able to participate in an active camp program. YES NO (Circle one)

The applicant is under a physician's care for the following condition(s) _____

_____

Treatment / medications to be continued while at Camp _____

_____

Activities to be encouraged or limited _____

_____

Additional health information _____

_____

Signature of Licensed Health Care Professional (MD, RN, NP, PA, DC, etc.) _____

Office Address _____ Office Phone _____
(Number Street Suite City State Zip) (Area Code / Number)

****

PHYSICIAN FORM **STOPS HERE.** BOX BELOW FOR CAMP WINNARAINBOW OFFICE USE **ONLY.**

****

SECTION VIII: TO BE COMPLETED ONLY BY CAMP WINNARAINBOW MEDICAL DEPT

In-Camp Screening Record Completed by _____ Date _____ Health History Checked _____

Eyes: No Problem _____ Observations_____

Nose: No Problem _____ Observations _____

Ears: No Problem _____ Observations _____

Throat: No Problem _____ Observations _____

Skin: No Problem _____ Observations _____

Head Lice or Nits Observed? Yes _____ No _____ Action taken _____

Other Observations of illness, disability or communicable disease _____

Follow up recommended? Yes _____ No _____ Action taken _____

Record of medications brought to Camp _____

Instructions regarding medications_____

Questions to ask Custodian / Camper: How is Camper feeling today? _____

Have there been any changes since this form was filled out? Yes _____ No _____ Action taken _____

Has camper been exposed to any communicable diseases in the past 3 weeks? Yes ___ No ____ Action taken _____

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