



To be completed by Camp Staff

Nurse Check-in Complete:
 Yes No
 Date: _____
 Nurse's Initials: _____
 Comments: _____

Session(s) attending: _____

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

ADULT CAMPER / STAFF HEALTH HISTORY FORM

CONTACT INFORMATION

Name _____ Birth Date ____ / ____ / ____ Age ____ Gender ____
Last, First

Home Address _____
Number and Street Apt City State Zip

Home Phone _____ Cell Phone _____ Email _____
Area Code / Number Area Code / Number Please PRINT Clearly

Emergency Contact _____ Hm # _____ Alt # _____
Name Area Code / Number Area Code / Number

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

HEALTH HISTORY INFORMATION Please explain and date any "yes" answers.

Are you currently under the care of a physician? Yes No (circle one) _____

Do you have a chronic or recurring illness or medical condition of which our medical staff should be aware?
 Yes No (circle one) _____

If you have a medical condition for which you are receiving treatment (including illness, birth control, etc.) be sure to bring enough medication to cover treatment for the entire time you will be at Camp.

Any allergies or dietary restrictions (food, medications, plants, insects, etc.) Yes No (circle one) _____

Additional health information _____

Date of last tetanus shot? _____

INSURANCE INFORMATION Please attach a photocopy of insurance card(s) to this form.

Do you have medical/hospital insurance? Yes No (circle one) Group/Policy number _____

Name of policy holder _____ Group name _____

Carrier/Company name _____ Phone _____
Area Code / Number

Address _____
Number and Street Suite Number City State Zip

IMPORTANT - The box below MUST be completed for attendance

This health history is correct and complete to the best of my knowledge.

I give permission for Camp Winnarainbow (CWR) to provide routine health care, administration of prescribed medications and emergency treatment for me 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 emergency transportation, if necessary. I agree to the

release of any records necessary for treatment, referral, billing, or insurance purposes.

In the event of an emergency, I hereby give permission to the Health Care Professional(s) selected by CWR to secure and administer appropriate treatment, including hospitalization, for me if I cannot and if my emergency contact cannot be reached. I understand that I am financially responsible for any treatments I may receive while at Camp Winnarainbow. This completed form may be photocopied.

Signature of Adult Camper or Staff _____
 Printed Name _____ Date _____