Camp Winnarainbow

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 _____

September - May: 1301 Henry Street, Berkeley, CA 94709 • June - August: PO Box 1359, Laytonville, CA 95454
Phone: 510/525-4304 fax: 510/528-8775 • Phone: 707/984-6507 fax: 707/984-8087
Year-round email: arainbow@mcn.org • Internet: www.campwinnarainbow.org