

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

This person takes medications as follows: **OR** This person **takes NO medications** on a routine basis.
Med #1 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____
Med #2 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____
Attach additional pages for more medications.
Identify any medications taken during the school year that participant does/may not take during the summer. _____

RESTRICTIONS (The following restrictions apply to this individual.)

Does not eat: Red meat Pork Dairy Products Poultry Seafood Eggs Other (describe) _____

Explain any restrictions to activity (what cannot be done, what adaptations or limitations are necessary)

GENERAL QUESTIONS (Explain "yes" answers below.)

Has/does the Camper:	Yes	No		Yes	No
1. Had any recent injury, illness or infectious disease? ...	<input type="checkbox"/>	<input type="checkbox"/>	15. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	16. Ever had back problems?.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had problems with joints (knees, ankles, etc.)....	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	18. Have an orthodontic appliance being brought to camp?.	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems (itching, rash, acne).....	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?.....	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	24. Have problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	25. Have a history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	26. If female, have started menstrual cycle?	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	27. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
14. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	28. Have a history of being afraid of the dark?	<input type="checkbox"/>	<input type="checkbox"/>

Please explain any "yes" answers, noting the number of the question & explain any fears/problems that are not listed _____

Is this your child's first time away from home? _____

Use this space to provide any additional information about the camper's behavior and physical, emotional, or mental health which the camp should be aware. _____

Name of family physician _____ Phone _____

Address _____

Name of family dentist/orthodontist _____ Phone _____

Address _____

Important - This box must be complete for attendance

Parent/Guardian Authorizations: All reported information regarding my child is correct to the best of my knowledge. I have read the Camp information and give my permission for my child to engage in all learning and recreational activities and trips at Wildwood, except as noted by me on this form. Further, I understand that some trips may be away from Wildwood's main facility. I agree to hold the Wildwood Outdoor Education Center, Inc., its employees, officers, directors and agents, harmless for any accident, injury and/or accident, which may occur in this program.

I also give my permission for the Wildwood Outdoor Education Center to use any photographs or videos taken of my child for promotional purposes.

It is my intention that the camp be treated as acting *in loco parentis* if the person herein named is a minor. In the event I cannot be reached in case of an emergency, I hereby consent that the physician selected by the Wildwood Outdoor Education Center may hospitalize and secure proper treatment for my child, including, without limitation, order injection, anesthesia or surgery for my child as named above. I release and hold the Wildwood Outdoor Education Center, Inc., its employees, officers, directors, and agents harmless from any injury or accident to my child which may occur from such activity by the Wildwood Outdoor Education Center, Inc. or such physician.

Signature of parent or guardian _____

Printed Name _____ Date _____