

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_

Birthday: \_\_\_\_\_

Health Form  
Camp Wakonda  
5045 Dyewood Road SW  
Sherrodsville, OH 44675



Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

How much does your child weigh? This information is needed to accurately measure dosages for over the counter medications. \_\_\_\_\_

Please list all medications for the child. Anything on this list needs to be turned in to the nurse when signing in at camp. All medications must be in their original containers. All medications of any kind that come to camp must be turned in to the nurse.

Medication Name	Dosage	Expiration Date	Prescribed to child? Y or N

I give permission for the trained, on-site medical personnel to give over-the-counter medication (Ibuprofen, acetaminophen, allergy medicine, hydrocortisone, etc.) for any symptoms that may occur at camp. Please list them in the medication section if taken often. Initial Here: \_\_\_\_\_

What over-the-counter medication do you normally give this child? \_\_\_\_\_

What form of this medication does this child prefer? Select all that apply. Liquid   Chewable   Pills   Topical

List any chronic conditions, illnesses, or injuries. Please attach any medical care plans.

\_\_\_\_\_  
\_\_\_\_\_

Are there any mental health considerations we should be aware of that would be relevant to camp participation?

\_\_\_\_\_  
\_\_\_\_\_

Please list all parents/guardians that are relevant.

<p>Parent/Guardian</p> <p>Name (First and Last) _____</p> <p>Relationship to Camper _____</p> <p>Address _____</p> <p>City _____ State ___ Zip _____</p> <p>Phone _____</p>	<p>Parent/Guardian</p> <p>Name (First and Last) _____</p> <p>Relationship to Camper _____</p> <p>Address _____</p> <p>City _____ State ___ Zip _____</p> <p>Phone _____</p>
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<p>Parent/Guardian</p> <p>Name (First and Last) _____</p> <p>Relationship to Camper _____</p> <p>Address _____</p> <p>City _____ State ___ Zip _____</p> <p>Phone _____</p>	<p>Parent/Guardian</p> <p>Name (First and Last) _____</p> <p>Relationship to Camper _____</p> <p>Address _____</p> <p>City _____ State ___ Zip _____</p> <p>Phone _____</p>
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Please list two people who can serve as emergency contacts IN ADDITION to the Parents/Guardians.

<p>Emergency Contact</p> <p>Name (First and Last) _____</p> <p>Relationship to Camper _____</p> <p>Address _____</p> <p>City _____ State ___ Zip _____</p> <p>Phone _____</p>	<p>Emergency Contact</p> <p>Name (First and Last) _____</p> <p>Relationship to Camper _____</p> <p>Address _____</p> <p>City _____ State ___ Zip _____</p> <p>Phone _____</p>
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Does the camper have Health Insurance? \_\_\_\_\_ Company/Policy # \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

Family Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Please circle any that may apply to the child: ADD/ADHD Autism Asthma Bedwetting

Preferred hospital: \_\_\_\_\_

Please provide any further information that will help us support your child while they are at camp.

Dietary Requirements, if any - Please be specific and attach a separate sheet of paper if necessary.

Has this child had any recent illness or injury? If yes, please explain. Yes No

Food/Environmental/Drug Allergies - Please be specific and attach a separate sheet of paper if necessary. Please attach any allergy treatment plans.

In the event that I cannot be reached, I hereby give permission to the Wakonda staff to determine the best treatment, including all emergency care measures, surgery, anesthesia, and hospitalization. Yes No Initials\_\_

Check the immunizations the child has received:  
\_\_\_\_ All required immunizations  
\_\_\_\_ Chicken Pox  
\_\_\_\_ Tetanus Date of last Tetanus \_\_\_\_\_

My child has permission to engage in all activities at camp.  
Yes No If no, please explain:

Please sign below to acknowledge that this form is complete and accurate to the best of your knowledge.

Camp Nurse: have parent initial below after reviewing this form with them at check-in

\_\_\_\_\_

\_\_\_\_\_