CAMP HEALTH EXAMINATION FORM

Developed by the American Camping Association in consultation with The American Medical Association and the American Academy of Pediatrics

Name:_____ **Birth date:** _____**Gender: M:**☐**F:**☐ **Age:**_____
Last First M. Init.

Name of Parents/Guardians
(or spouse): _____**Phone:** _____

Home Address:_____
Street City State Zip

Email Address:_____

Church: _____
If not available in an emergency please notify:

1. _____Phone: _____
   Name Relationship
2. _____Phone: _____
   Name Relationship

Check all that apply, giving approximate dates

Health History	Date	Allergies	Date	Diseases	Date
☐ Frequent Ear Infections	_____	☐ Hay Fever	_____	☐ Chicken Pox	_____
☐ Heart Defect/Disease	_____	☐ Poison Ivy, etc.	_____	☐ Measles	_____
☐ Convulsions	_____	☐ Insect Stings	_____	☐ German Measles	_____
☐ Diabetes	_____	☐ Penicillin	_____	☐ Mumps	_____
☐ Bleeding/Clotting Disorders	_____	☐ Other Drugs	_____	☐ Asthma	_____

Allergies (describe reactions/treatment):
_____

Operations or serious injuries and dates:
_____

Chronic or recurring illnesses:
_____

Dentist/Orthodontist: _____Phone: _____
Family Doctor: _____ Phone: _____
Medical/Health Insurance Company:_____**Policy or Group #:**_____
IMPORTANT: *Please notify us if this individual is exposed to any communicable disease during the three weeks prior to attending.*

Medications: ***All medications must be in original pill bottles!***

Medication 1: _____ Dosage: _____ Administer at: (Check all that apply) ☐breakfast ☐lunch ☐dinner ☐bed ☐other Reactions: _____

Physician: _____ RX#: _____ Route of Administration: _____ Date: _____

Medication 2: _____ Dosage: _____ Administer at: (Check all that apply) ☐breakfast ☐lunch ☐dinner ☐bed ☐other Reactions: _____

Physician: _____ RX#: _____ Route of Administration: _____ Date: _____

(If more medications are necessary please use the back of this form)

IMPORTANT: MUST BE COMPLETED FOR ATTENDANCE

Parental Authorization. This health history is correct so far as I know, and the person described herein has permission to engage in all prescribed activities. In the event of an emergency, I hereby give permission to the physician selected by the Expeditions Unlimited staff to order X-rays, routine tests and treatment for the health of my child. In the event that I cannot be reached in an emergency, I also give permission to the physician selected by the Expeditions Unlimited staff to hospitalize, secure proper treatment for, to order injection and/or anesthesia and/or surgery for my child as named above.

Parental Signature:_____ **Date:**_____

Release of Claims and Waiver of Liability

The undersigned applicant acknowledges, understands and agrees that as to the contemplated trip with Expeditions Unlimited:

1. There are unique physical demands and risks involved;
2. The activity can be of a dangerous nature which can result in serious and potentially fatal injury;
3. That instructions given must be followed for ongoing participation and safety of the applicant; and
4. That Expeditions Unlimited, Ltd. retains the right of final approval of all participants and the right to terminate a participant's involvement in a trip at its discretion.

In consideration of conducting the trip and based on the above, Expeditions Unlimited, Ltd., it's officers, directors, shareholders, employees, agents and their heirs, executors and assigns are released as to any and all claims for damages, including but not limited to injuries, whether to person or property, known or unknown that the undersigned has or may have in the future arising out of and in connection with the contemplated trip.

Release as to Photographic, Movie and Video Images
The undersigned irrevocably consents to and authorizes the use and reproduction of any and all photographic and video images taken during the contemplated trip. The use and reproduction of images is at the discretion of Expeditions Unlimited whether for advertising, promotional or other legal purposes without additional consideration or compensation to the undersigned. Originals and copies or images are and will remain the sole property of Expeditions Unlimited, Ltd.

Applicant Information
Complete the following information for each member of your household participating in the trip with Expeditions Unlimited.

Name(s)

Address

City State Zip

Applicant's Signature Date of Birth

Applicant's Signature Date of Birth

Applicant's Signature Date of Birth

Applicant's Signature Date of Birth

Applicant's Signature Date of Birth

Parent or Guardian Signature _____Date____/____/____
*Required if applicant is under 18 years of age

E11844 County Road DL
Baraboo, WI 53913

Telephone (608) 356-4004
Fax (608) 356-4185

Food Allergy Action Plan

*Completion of this form is necessary **only** if participant has a food allergy*

Name: _____

Group: _____

Allergy To: ☐ Dairy ☐ Wheat ☐ Eggs ☐ Peanuts ☐ Tree Nuts ☐ Other: (Please list)

_____

Physician: _____ Phone #: _____

Emergency Numbers
Name: _____ Phone #: _____

Name: _____ Phone #: _____

PLEASE TELL US WHAT TO DO IN CASE OF AN ALLERGIC REACTION
CHECK ALL THAT APPLY

This Occurs:
My Child's allergic reaction includes:

- ☐ Swelling, itching raised skin rash
- ☐ Generalized body flush, swelling or itching
- ☐ Nausea, abdominal cramps, vomiting and/or diarrhea
- ☐ Itching and swelling of lips, throat, or tongue causing hoarseness, swallowing difficulty, coughing, wheezing or shortness of breath.
- ☐ "Thready" pulse, "passing out"
  - These signs may occur
    - ☐ Within a few minutes
    - ☐ Within 30 minutes to 2 hours

The severity of symptoms can quickly change. All above symptoms can potentially progress to a life-threatening situation.

General First Aid

- Observe for 30 minutes
- Notify Parents
- ☐ Administer oral medication And
  Name _____ _____
  Dosage _____ _____
- ☐ Administer adrenaline (Epi Pen)
  - ☐ Immediately
- ☐ If symptoms occur (describe)

Student can self-administer Epi Pen? ☐ Yes ☐ No

If Epi pen is administered, an ambulance, then parents will be notified

** ***Please Note**: Expeditions Unlimited **cannot** provide specialized meals for participants but we can provide a couple of additional options, as well as inform students of the ingredients found in prepared food.*

Please return this form **2 weeks** prior to scheduled arrival date.
If returned later than **2 weeks** additional options may not be available.

Comments regarding other accommodations: _____

Parental Signature: _____ Date: _____