NIGHT EAGLE WILDERNESS ADVENTURES * P. O. Box 479 * Wallingford, VT 05773
Phone: (802) 446-6100 E-mail: bruce@nighteaglewilderness.com

Camper & A.C. Health History and Examination Form

(This side is to be completed by parents/guardian of campers and assistant counselors)

Name _____ Birthdate _____
Last *First* *Initial*
Parents or Guardian_____

Home Address _____ Home Phone_____
Street & Number
_____ Business Phone _____
City *State* *Zip*
Second Parent or Guardian (or Emergency Contact) _____

Home Address _____ Home Phone _____
Street & Number
_____ _____Business Phone _____
City *State* *Zip*
If not available in an emergency, notify:
Name _____ Relationship _____

Home Address _____ Phone _____

Health History:

(Check. Give approximate dates)
_____ Frequent Ear Infections
_____ Heart Defect/Disease
_____ Convulsions/Seizure Disorder
_____ Diabetes
_____ Bleeding/Clotting Disorders
_____ Hypertension
_____ Mononucleosis
_____ Psychiatric Treatment

Has camper ever required psychiatric counseling/hospitalization? _____
Explain _____
Operations or serious injuries (*dates)* _____
Disability or chronic or recurring illness _____
Activities encouraged/limited by physician_____
Dietary modifications_____
Name of dentist/orthodontist _____ Phone_____
Name of family physician _____ Phone_____
Date of last physical exam_____

Diseases:

_____ Chicken Pox
_____ Measles
_____ German Measles
_____ Mumps

Allergies (Dates Not Needed):

_____ Hay Fever
_____ Ivy Poisoning, etc.
_____ Insect Stings
_____ Penicillin
_____ Other Drugs
_____ Asthma
_____ Food item
_____ Other *(Specify)*

Health and Accident Insurance Co. _____
Address _____
_____
Phone _____
Group Policy # _____
Individual Policy #_____
Policy under name of (Subscriber)_____

Subscriber's social security number_____

Subscriber's Date of Birth_____
You must attach a copy of your insurance card (+prescription card) to the form

Important - The following must be completed for attendance

This health history is correct to the best of my knowledge, and the person herein described has permission to engage in all prescribed camp activities except as noted. I hereby give permission to the medical personnel selected by the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment, including x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. Any medical bills incurred for treatment are my responsibility. This completed form may be copied.

Signature of parent or guardian _____ **Date**_____
I understand and agree to abide with the restrictions placed on my camp activities.

Signature of Camper or A.C. _____

Immunization History

Required immunizations must be determined locally. Please record the date (month and year) of basic immunizations and most recent booster doses.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 2 Month/Year	Dose 2 Month/Year	Dose 2 Month/Year	Most Recent Dose Month/year
Diptheria, Tetanus, Pertussis* (DTaP) or (TdaP)						
Tetanus Booster* (dT) or (TdaP)						
Mumps, Measles, Rubella* (MMR)						
Polio* (IPV)						
Haemophilus Influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella ____ Had Chicken Pox Chicken Pox Date:						
Meningococcal Meningitis (MCV4)						

Tuberculosis (TB) test	Date:	_____ Negative _____ Positive

If your son has not been fully immunized, please sign the following statement: I understand and accept the risks to my child from not being fully immunized.

Signature of Custodial Parent/Guardian: _____ Date: _____ Relationship to Camper: _____

Medication: _____ This camper will take the following medication(s) while attending Night Eagle.

Medication is any substance a person takes to maintain and/or improve his health. This includes vitamins & natural remedies. **Vermont requires original pharmacy containers with labels** which show the camper'**s** name and how the medication should be given.

Provide enough of each medication to last the entire time your son will be at camp.

Name of medication	Date started	Reason for taking it	When it is given	Amount or dose given	How it is given
			_____ Breakfast _____ Lunch _____ Dinner _____ Bedtime _____ Other time:		
			_____ Breakfast _____ Lunch _____ Dinner _____ Bedtime _____ Other time:		
			_____ Breakfast _____ Lunch _____ Dinner _____ Bedtime _____ Other time:		

I have examined the above camp applicant within the past two years. Date Examined _____

In my opinion, this child **is able / is not able** to participate in an active summer camp program without restrictions. (Circle one)

The applicant is under the care of a physician for the following condition(s): _____

Height _____ Weight _____ Blood Pressure _____

Licensed Physician's Signature _____

Address _____ Phone _____ Street & Number
City State Zip Area/Number

Date of Form Completion _____ *By _____
*Initial if completed by nurse or physician's assistant