Health, Wellness, Medical and Insurance

As part of tuition, campers are cared for by our team of nurses at the Wyonegonic Health Center. The nurses follow standing orders by the camp doctor and after assessment of the camper nurses may dispense medication from the stocked inventory. The nurses are also involved with risk management planning, primary care of injuries, dispensing of prescription (RX) medications and supplies, preparations and briefing for our trip program and following the standards of the American Camp Association for Health and Wellness.

HEALTH INSURANCE: Pre-existing conditions, prescribed medications and accidents fall under the responsibility of the family medical insurance policy. Therefore, it is important that we have appropriate details of your camper's health insurance policy on file in the Wyonegonic Health Center.

HEALTH: It is mandatory that everyone in camp returns the green and pink health forms sent in the February mailing and details of your health insurance. Please mail these forms by June 1 (or July 1 for Session II) because nurses will be reviewing these completed forms the week of June 4th. The form is kept on file (in confidence) in our Health Center and must be complete with parent signature and CURRENT health history. A primary care physician signature and proof of physical exam (since July 1, 2010) is required.

Please inform us if your child has been exposed to any communicable disease or head lice. Our camp personnel screen campers upon arrival, but updated information is critical.

It is our policy to inform you of any accident or illness that requires a visit to the doctor or more than a one-night stay in our Health Center.

MEDICATIONS (new program): We encourage you to arrange pre-packaged medications through *CampRX*. This provides the Wyonegonic nurses and your child with a safeguard system for dispensing and control of all meds. It also assures that pre-packaged meds will be sent on all out-of-camp trips and be dispensed by a designated trip leader.

Please open an account at www.CampRX.com for a simple and convenient way to send necessary medications to camp. The *CampRX* service coordinates your child's prescriptions (RX) and over the counter medications (OTCs) to create customized packets of multiple medications. *CampRX* ships the personalized packets directly to camp before the season begins. The company recommends you submit your RX and OTC orders 60 to 30 days prior to your camper's arrival to camp. Wyonegonic is partially subsidizing this program to assist the nurses.

If you choose not to use the *CampRX* system, all medications must come properly labeled, in their original containers, with a doctor's signature and instructions translated in English. This includes over the counter meds or vitamins**. OTCs will not be dispensed without a doctor's signature.** No medication is allowed in camper cabins. All medications are secured in the Wyonegonic Health Center and dispensed by RNs except for out-of-camp trips. Pre-packaged meds will be dispensed by a designated trip leader when your child is on a canoe trip or hike.

HOSPITAL: Our nurses follow standing orders from Drs. Craig and Jennifer Smith who are associated with the Bridgton Hospital. The hospital is located 6 miles from camp. We use the Bridgton Hospital for Urgent Care and Emergency Room if needed and Central Maine Medical Center in Lewiston for crisis care. In the event the parent cannot be reached, it is understood that the directors and the camp nurses have the authority to act upon the recommendation of an attending physician in case of medical treatment or surgical necessity.

CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

Mail this form to the address below by 6/1 ***(date)***

Wyonegonic Camps, Inc
[illegible] Wyonegonic Rd
[illegible]

Dates will attend camp: from ______________ to ______________
Month/Day/Year Month/Day/Year

Camper Name: ____
First Middle Last

☐ Male ☐ Female Birth Date ______________ Age on arrival at camp: ________
Month/Day/Year

To Parent(s)/Guardian(s): Please follow the instructions below. Attach additional information if needed.

1) ***Complete pages 1, 2 and 3 of this form (FORM 1) and make a copy.***
2) ***Send the original, signed FORM 1 to camp by the requested date.***
3) ***Complete the top of FORM 2 (CAMPER HEALTH-CARE RECOMMENDATIONS) and provide the copy of FORM 1 with FORM 2 to your child's health-care provider for review and completion.***
4) ***After it has been completed and signed by your child's health-care provider, return FORM 2 to camp by the requested date.***

Camper Home Address: ____
Street Address City State Zip Code

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name: ______________________ Relationship to Camper: ______________ Preferred Phones: (_____) ______________ (_____) ______________

Email: ______________________

Home Address: ____
(If different from above) Street Address City State Zip Code

Second parent/guardian or other emergency contact:

Name: ______________________ Relationship to Camper: ______________ Preferred Phones: (_____) ______________ (_____) ______________

Email: ______________________

Additional contact in event parent(s)/guardian(s) can not be reached:

Name(s): ______________________ Relationship to Camper: ______________ Preferred Phones: (_____) ______________ (_____) ______________

Allergies: ☐ No known allergies. ☐ This camper is allergic to: ☐ Food ☐ Medicine ☐ The environment (insect stings, hay fever, etc.) ☐ Other
(Please describe below what the camper is allergic to and the reaction seen.)

Diet, Nutrition: ☐ This camper eats a regular diet. ☐ This camper eats a regular vegetarian diet.
☐ This camper has special food needs. ***(Please describe below.)***

Restrictions: ☐ I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.
☐ I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations. ***(Please describe below.)***

Medical Insurance Information:

This camper is covered by family medical/hospital insurance ☐ Yes ☐ No

Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.

Insurance Company______________________ Policy Number______________________

Subscriber______________________ Insurance Company Phone Number (_____) ______________

Parent/Guardian Authorization for Health Care:

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Custodial Parent/Guardian ______________________ Date: ______________ Relationship to Camper: ______________

If for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

Camper Name ______ First ______ Middle ______ Last ______

(For Camp Use) Cabin or Group ______

(For Camp Use) Session Code(s): ______

CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

Camper Name: _____
First Middle Last

Birth Date: _____
Month/Day/Year

Immunization History: Provide the month and year for each immunization. Starred (★) immunizations must be current. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 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 (chicken pox) ☐Had chicken pox Date:						
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test	Date:	☐ Negative	☐ Positive

If your camper 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 not take any daily medications while attending camp.

☐ This camper will take the following daily medication(s) while at camp:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. ***Please review camp instructions about required packaging/containers. Many states require 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 the camper 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:_____		

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. ***Cross out those the camper should not be given.***

Acetaminophen (Tylenol)
Phenylephrine decongestant (Sudafed PE)
Antihistamine/allergy medicine
Diphenhydramine antihistamine/allergy medicine (Benadryl)
Sore throat spray
Lice shampoo or cream (Nix or Elimite)
Calamine lotion
Laxatives for constipation (Ex-Lax)
Ibuprofen (Advil, Motrin)
Pseudoephedrine decongestant (Sudafed)
Guaifenesin cough syrup (Robitussin)
Dextromethorphan cough syrup (Robitussin DM)
Generic cough drops
Antibiotic cream
Aloe
Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)

CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

Camper Name: _____
First Middle Last

Birth Date: _____
Month/Day/Year

General Health History: ***Check "Yes" or "No" for each statement. Explain "Yes" answers below.***

Has/does the camper:

1. Ever been hospitalized?	☐ Yes	☐ No	11. Had fainting or dizziness?	☐ Yes	☐ No
2. Ever had surgery?	☐ Yes	☐ No	12. Passed out/had chest pain during exercise?	☐ Yes	☐ No
3. Have recurrent/chronic illnesses?	☐ Yes	☐ No	13. Had mononucleosis ("mono") during the past 12 months?	☐ Yes	☐ No
4. Had a recent infectious disease?	☐ Yes	☐ No	14. If female, have problems with periods/menstruation?	☐ Yes	☐ No
5. Had a recent injury?	☐ Yes	☐ No	15. Have problems with falling asleep/sleepwalking?	☐ Yes	☐ No
6. Had asthma/wheezing/shortness of breath?	☐ Yes	☐ No	16. Ever had back/joint problems?	☐ Yes	☐ No
7. Have diabetes?	☐ Yes	☐ No	17. Have a history of bedwetting?	☐ Yes	☐ No
8. Had seizures?	☐ Yes	☐ No	18. Have problems with diarrhea/constipation?	☐ Yes	☐ No
9. Had headaches?	☐ Yes	☐ No	19. Have any skin problems?	☐ Yes	☐ No
10. Wear glasses, contacts, or protective eyewear?	☐ Yes	☐ No	20. Traveled outside the country in the past 9 months?	☐ Yes	☐ No

Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

Mental, Emotional, and Social Health: ***Check "Yes" or "No" for each statement.***

Has the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?	☐ Yes	☐ No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?	☐ Yes	☐ No
3. During the past 12 months, seen a professional to address mental/emotional health concerns?	☐ Yes	☐ No
4. Had a significant life event that continues to affect the camper's life? (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)	☐ Yes	☐ No

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

Health-Care Providers:

Name of camper's primary doctor(s): _____ Phone: (_____) _____

Name of dentist(s): _____ Phone: (_____) _____

Name of orthodontist(s): _____ Phone: (_____) _____

What Have We Forgotten to Ask? ***Please provide in the space below*** any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program. ***Attach additional information if needed.***

Parents/Guardians: STOP here. The rest of this is form is completed when the camper arrives at camp. Keep a copy for your records.

Rev. 1/2007 LEE/EAW

CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

Camper Name: _____
First Middle Last

Birth Date: _____
Month/Day/Year

Individual Health Record (For Camp Use Only)

Initial Screening **Date/Time:** _____ **Initials:** _____

☐ **Screening** has been conducted according to camp protocol and significant findings noted as follows:

A. Any signs/symptoms of illness or injury upon arrival?..... ☐ No ☐ Yes as noted below

B. History of exposure to communicable disease?..... ☐ No ☐ Yes as noted below

C. Additions or corrections to information on this health history?..... ☐ No ☐ Yes as noted below

D. Medication given to health-care staff?..... ☐ No ☐ Yes as noted below

E. Any signs/symptoms of head lice?..... ☐ No ☐ Yes as noted below

Provider notes: (date/time/initial all entries) _____

Exit Note: Check one of the following:

☐ Left camp this day with no reported illness or injury symptoms.

☐ Left camp this day with the following problem/concern:

_____

_____

This person was told about the problem and instructed about follow-up as noted above: _____

Date/Time: _____ Initials: _____

CAMPER HEALTH-CARE RECOMMENDATIONS by LICENSED MEDICAL PERSONNEL FORM 2

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

Mail this form to the address below by 12/1 ***(date)***

Wyonegonic Camps, Inc
215 Wyonegonic Rd
Denmark, ME 04022

To Parent(s)/Guardian(s): Complete this section *and give* ***this form (FORM 2) and a copy of your completed CAMPER HEALTH HISTORY FORM (FORM 1)*** *to your child's health-care provider for review.*

Dates will attend camp: from _____ (Month/Day/Year) to _____ (Month/Day/Year)

Camper Name: _____ (First) _____ (Middle) _____ (Last)

☐ Male ☐ Female Birth Date _____ (Month/Day/Year) Age on arrival at camp _____

Camper home address: _____

_____ (City) _____ (State) _____ (Zip Code)

Custodial parent(s)/guardian(s) phone: (_____)_____ (_____)_____

Parent(s)/guardian(s) stop here. Rest of form to be completed by medical personnel.

The following non-prescription medications are commonly stocked in camp Health Centers and are used on an as needed basis to manage illness and injury. ***Medical personnel: Cross out those items the camper should not be given.***

Acetaminophen (Tylenol)
Ibuprofen (Advil, Motrin)
Phenylephrine (Sudafed PE)
Pseudoephedrine (Sudafed)
Chlorpheneramine maleate
Guaifenesin
Dextromethorphan
Diphenhydramine (Benadryl)
Generic cough drops
Chloraseptic (Sore throat spray)
Lice shampoo or scabies cream (Nix or Elimite)
Calamine lotion
Bismuth subsalicylate (Pepto-Bismol)
Laxatives for constipation (Ex-Lax)
Hydrocortisone 1% cream
Topical antibiotic cream
Calamine lotion
Aloe

Medical Personnel: Please review the CAMPER HEALTH HISTORY FORM (FORM 1) and complete all remaining sections of this form (FORM 2). Attach additional information if needed.

Physical exam done today: ☐ Yes ☐ No (**If "No," date of last physical:** _____ Month/Day/Year)

ACA accreditation standards specify physical exam within last 24 months.

Weight: _____ lbs Height: _____ft_____in Blood Pressure_____/_____

Allergies: ☐ No Known Allergies

☐ To foods ***(list):***

☐ To medications: ***(list):***

☐ To the environment ***(insect stings, hay fever, etc.– list):***

☐ Other allergies: ***(list):***

Describe previous reactions:

Diet, Nutrition: ☐ Eats a regular diet. ☐ Has a medically prescribed meal plan or dietary restrictions:***(describe below)***

The camper is undergoing treatment at this time for the following conditions: ***(describe below)*** ☐ None.

Medication: ☐ No daily medications. ☐ Will take the following prescribed medication(s) while at camp: ***(name, dose, frequency—describe below)***

Other treatments/therapies to be continued at camp: ***(describe below)*** ☐ None needed.

Do you feel that the camper will require limitations or restrictions to activity while at camp? ☐ No ☐ Yes

If you answered "Yes" to the question above, what do you recommend? ***(describe below—attach additional information if needed)***

"I have reviewed the CAMPER HEALTH HISTORY FORM (FORM 1), and have discussed the camp program with the camper's parent(s)/guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above.)

Name of licensed provider (please print): _____ Signature: _____ Title: _____

Office Address _____ (Street) _____ (City) _____ (State) _____ (Zip Code)

Telephone: (_____)_____ Date:_____

Rev. 2/07 LEE/EAW

Camper Name _____ (First) _____ (Middle) _____ (Last) (For Camp Use) Cabin or Group _____ (For Camp Use) Session Code(s): _____