HEALTH FORM 2019 (For Wyonegonic Training Clinic Participants)

WYONEGONIC CAMPS, 215 Wyonegonic Rd, Denmark ME 04022
Tel: 207-452-2051 Fax: 207-452-2611 Email: training@wyonegonic.com

The information on this form is not part of the participants' acceptance process, but is gathered to assist us in identifying appropriate care.

Name: _____Birthdate:___/___/____ Male/Female
(Last) (First) (M.I.) (Nickname) (Month/Day/Year) (Circle one)
Address:_____

(Street) (Town) (State/Country) (Zip code)

Primary Parent/Guardian Name(s) (if under 18)_____

Primary Parent/Guardian telephone w/area code: (phone) _____

Name of emergency contact other than parent/guardian: _____(phone) _____

Health Insurance Information: _____Policy #_____(phone)_____

Health Information to be provided by participant parent(s)/guardian(s) or adult staff:
The intent of this information is to provide healthcare personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Changes to the information on this form should be provided in writing to Wyonegonic Camps upon participant's arrival in camp. Provide complete information so that the camp and course instructors are aware of any health needs.

1. ALLERGIES: **YES/NO** (if **YES**, please list) _____
Medication Allergy: **YES/NO** (if **YES**, please list) _____
Food Allergy: **YES/NO** (if **YES**, please list) _____
Other Allergy: **YES/NO** (if **YES**, please list) _____

2. ASTHMA: **YES/NO** (if **YES**, please list known trigger, frequency & treatment) _____

_____

Inhaler: (if **YES, please indicate typical use in a week or month) _____

3. EPI PEN or ANA KIT: **YES/NO** (if **YES**, please list circumstances, describe reaction & management) _____

___ _____

4. CONDITIONS OR RESTRICTIONS affecting your ability to participate in the training clinic:

_____

SIGNATURE REQUIRED BELOW

This form is correct and complete to my best knowledge. The person herein described has permission to engage in all training clinic activities except as noted above. I understand I am responsible for safely securing my personal prescriptions while at Wyonegonic. I understand the Wyonegonic Health Center is NOT open as a nursing station during training clinic dates in June. Therefore, in the event I need basic medical care, I will provide full medical records, transportation to medical facilities and personal insurance.

In the event of a need for emergency medical care, Wyonegonic staff will assist with any emergency medical care until EMS personnel arrive. I hereby give permission to Wyonegonic Camps to seek any necessary emergency medical treatment. I agree to the release of records necessary for treatment, referral, billing or insurance purposes. I give permission to the camp to arrange necessary related transportation in the event of an emergency. In the event I cannot be reached in an emergency, I hereby give permission to the physician or health facility selected by Wyonegonic Camps to secure and administer treatment, including hospitalization, for the person named above.

Circle One:

I have seen a physician within the past 24 months and am cleared for physical activity as required by this training.

I am signing this waiver as a religious exemption

***Signature of participant OR parent/guardian (under age 18)**

_____ _____
(Signature) (Date)