Camp Amnicon Contact, Consent, and Health Form

This form must be completed by ALL trip participants, including adults. Provide this form to a licensed health-care provider to complete and sign the final page. If the trip participant has received a physical exam within the last year, you may attach the form from said physical. ***THIS FORM MUST BE SIGNED BY A PARENT/GUARDIAN AND A LICENSED HEALTH-CARE PROVIDER TO ATTEND.*** Bring the completed form with you to camp. Items with a * will be double-checked in a health interview upon arrival to camp. Please contact Camp Amnicon at 715-364-2602 with questions.

Contact Information:

Participant Information:

Name_____ Birth Date_____ Gender_____ Age upon arrival at camp____

Race (circle all that apply) *African American* *Asian/Pac. Islander* *Caucasian* *Latino* *Native American* *Other*

Street Address: _____ City:_____ State: _____ Zip Code: _____

E-mail: _____ Phone: _____

Primary/Emergency Contact in case of illness or injury*:*

Name _____Preferred phones:_____, _____

Street Address: _____ City:_____ State: _____ Zip Code: _____

Relationship to participant:_____ E-mail: _____

Second Contact or other Emergency Contact:

Name _____ Preferred phones:_____, _____

Street Address: _____ City:_____ State: _____ Zip Code: _____

Relationship to participant:_____ E-mail: _____

Additional contact in event other contacts cannot be reached:

Name _____ Relationship:_____

Preferred phones:_____, _____

Consent:

1. In consideration with the services of Camp Amnicon and all employees and persons associated with that business (hereinafter collectively referred to as "Camp Amnicon"), I agree as follows: Although Camp Amnicon has taken reasonable steps to provide me with appropriate equipment and skilled guides, Camp Amnicon has informed me that this activity is not without risk. Certain risks are inherent in each activity and cannot be eliminated without destroying the unique character of the activity. These risks include: loss or damage to my equipment, accidental injury, illness, or in extreme cases, permanent trauma or death. Camp Amnicon does not want to frighten me or reduce my enthusiasm for this activity, but believes it is important for me to be informed in advance of the inherent risks. I agree to accept and assume full responsibility for the inherent risks identified herein, and those inherent risks not specifically identified. My/my child's participation in this activity is purely voluntary, and I/my child agree(s) to participate in spite of and with full knowledge of the inherent risks. I acknowledge that while engaging in this activity I and/or my child have responsibilities as a participant. I acknowledge that I and/or my child have been or will be provided with a properly fitted, serviceable personal floatation device (PFD) before participating in any aquatic activities with Camp Amnicon, and that all participants are required to wear said PFD anytime they are in an aquatic vessel (canoe, kayak, paddleboard, or any other water craft). I acknowledge that the staff of Camp Amnicon are available to more fully explain to me the nature and physical demands of this activity and the inherent risks and hazards associated with this activity. I certify that I and/or my child are fully capable of participating in this activity. Therefore, I assume and accept full responsibility for myself/my child for bodily injury, death, or loss of personal property and expenses and any inherent risks and hazards not specifically identified, or anything that may result from my/my child's negligence while participating in this activity. I have carefully read, clearly understood, and accepted the terms and conditions stated herein and acknowledge that this agreement shall be effective and binding upon myself and all members of my family including my children.

2. This health history is correct and complete as far as I know. The person herein described has my permission to engage in all camp activities including those listed in the brochure, program information sheet, and "Information for Campers/Parents", except as noted. I hereby give permission to the camp to provide routine health care, dispense medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for me/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. This completed form may be photocopied for trips out of camp.

3. I hereby authorize and consent to the use of my/my child's visual image, first name, likeness, voice and statements by Camp Amnicon to illustrate and promote the camp experience in media including but not limited to social media, print, and websites. I give this consent with no claim for payment. *(If you wish you/your child to be exempt from use in camp media, you may cross out part 3.)*

Signature of Trip Participant_____ Date: _____

Or parent/guardian if under 18

For Camp Use Only

How is the participant feeling about the trip? _____

Recent/Current illness/injury? _____

Double check starred items and any items of concern: _____

_____

Notes from health interview: _____

_____

_____

Health Interview Complete?

Participant Name: _____ **Page 2**

Medical Insurance Information This camper is covered by family medical/hospital insurance □ Yes □No

Please include a copy of your insurance card if possible. Copy both sides of the card so information is readable.

Insurer Name:_____ Provider Services Phone:_____

Group #:_____ ID #:_____ Policy Effective Date: _____

Subscriber Name: _____ Subscriber Birthdate: _____ Relationship: _____

Health Care Providers:

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

Name of dentist/orthodontist:_____ Phone: (___)_____

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

Has/does the trip participant:

*1. Ever been hospitalized?.....	□ Yes	□ No	*11. Have a bleeding or clotting disorder?.....	□ Yes	□ No
*2. Ever had surgery?	□ Yes	□ No	*12. Passed out/had chest pain during exercise?	□ Yes	□ No
*3. Had a recent or chronic illness or infectious disease?.....	□ Yes	□ No	*13. Had unexplained fainting, dizziness or unconsciousness?.....	□ Yes	□ No
*4. Had a recent or chronic injury?.....	□ Yes	□ No	*14. Get frequent ear infections?.....	□ Yes	□ No
*5. Had asthma/wheezing/shortness of breath…	□ Yes	□ No	*15. Have problems falling asleep/sleepwalking?	□ Yes	□ No
*6. Have diabetes?.....	□ Yes	□ No	*16. Ever had back/joint problems?.....	□ Yes	□ No
*7. Had seizures?.....	□ Yes	□ No	*17. Have problems with diarrhea/constipation?.	□ Yes	□ No
*8. Had problematic headaches?.....	□ Yes	□ No	18. Have any skin problems?.....	□ Yes	□ No
*9. Have high blood pressure or heart problems?	□ Yes	□ No	19. Had mononucleosis in the last year?.....	□ Yes	□ No
*10. Had a head injury or concussion?.....	□ Yes	□ No	20. If female, have problems with periods?.....	□ Yes	□ No

Please explain "Yes" answers in the space below, along with management strategies, noting the number of the question for each.

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

Has the trip participant:

1. Ever exhibited, been diagnosed with, or been treated for ADD or AD/HD?..... □ Yes □ No

*2. Ever exhibited, been diagnosed with, or treated for mental, emotional, behavioral or social difficulties..... □ Yes □ No
(i.e. depression, bipolar, ODD, anxiety, autism, OCD, suicidal ideation, others)

3. Ever exhibited, been diagnosed with, or treated for an eating disorder?..... □ Yes □ No

4. During the past 12 months, seen a professional to address mental/emotional health concerns?..... □ Yes □ No

5. Had a significant life event that continues to affect the camper's life?..... □ Yes □ No
(i.e. history of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Please explain "Yes" answers in the space below, along with management strategies, noting the number of the question for each.

*** Allergies:** Please describe below what the participant is allergic to, what reaction is seen, and how reactions should be managed.

□ No known allergies

□ This camper is allergic to:

□ Food □ Medicine □ Other

□ Environmental (bee stings, hay fever, etc.)

*** Diet/Nutrition:** □This participant eats a regular diet

□ This participant requires the following dietary accommodations (please describe):

For significant dietary needs, please call camp at 715-364-2602 prior to arrival.

*** Medication** □This participant will not need any special medications at camp

□This particpant has recently stopped taking the following medication(s): _____

□This participant will take the following medications at camp:

Name of Medication	Date Started	Reason for taking it	When it is given	Amount or dose given	Other instructions

Attach additional information as needed.

"Medication" is any substance a person takes to maintain and/or improve health. This includes vitamins and natural remedies.

Please pack medications in their original pharmacy bottles, with detailed instructions, in a water-proof container or bag. Provide enough of each medication to last the length of the trip.

Immunization History: Provide the month and year for each immunization.

A date for the latest Tetanus Booster must be given in order to attend. Copies of immunization forms are acceptable; please attach.

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
***Tetanus booster (dT or TdaP)**						
Diptheria, tetanus, pertussis (DTaP or TdaP)						
Mumps, measles, rubella (MMR)						
Polio (IPV)						
Haemophilus influenza type B (HIB)						
Pneumococcal (PVC)						
Hepatitis B						
Hepatitis A						
Varicella (Chicken Pox) — Had chicken pox. Date:____						
Meningococcal meningitis (MCV4)						

If the participant has not been fully immunized, please sign the following statement:

I understand and accept the risks to the participant from not being fully immunized.

Parent/Guardian signature: _____ Date: _____

What Have We Forgotten to Ask? In the space below, please provide any additional information that will help us to fully care for the participant's health and well-being during their participation in this trip. *Attach any additional information if needed.*

Parents/Guardians/Adult campers: STOP here.

The rest of this form must be completed and signed by licensed medical personnel for this person to participate.

This page to be completed by a licensed medical professional

Medical personnel: Please review the enclosed health history and complete all remaining sections of this form. Attach additional information if necessary.

Physical exam done today: □ Yes □ No
If 'No,' date of last physical: _____
Camp Amnicon requires a physical within the last 12 months.

The following non-prescription medications are stocked in Camp Amnicon's first aid kits 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.**

- Triple Antibiotic Ointment
- Acetaminophen (Tylenol)
- Aspirin
- Ibuprofen (Advil, Motrin)
- Phenylephrine (Sudafed PE)
- Diphenhydramine (Benadryl)
- Bismuth subsalicylate (Pepto-Bismol)
- Hydrocortisone 1% Cream
- Caladryl Lotion
- Anti-fungal Cream
- Saline eye-wash
- Pseudophedrine (Sudafed)

Weight: _____lbs Height: ____ft ___in Blood Pressure____/____

Allergies: □ No known allergies
□ To foods ***(list):***
□ To medicines ***(list):***
□ To the environment (bee 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 currently undergoing treatment for the following conditions: ***(Describe below)*** □ None

Medication: □ No prescribed 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? □ Yes □ No
If yes, what do you recommend? (Describe below—attach additional information if needed.)

Other Comments:

Signature Required!

This person will attend a wilderness trip lasting up to one week involving moderate physical activity, frequent contact with water, and remoteness from immediate professional medical care. With questions call (715)364-2602.

"I have reviewed the enclosed health history. It is my opinion that the participant is physically and emotionally fit to participate in this camp program (except as noted above.)

Name of licensed provider (please print): _____

Signature:_____ Title: _____

Office Address: _____

Telephone:_____ Date: _____