Camp Amnicon Wilderness Adventure Health Form

This form must be completed by all trip participants. All information provided on this form is kept confidential and used only in the event of an emergency. 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 documentation of that physical in lieu of the physician's signature. Bring the completed form with you to camp. Contact Amnicon at 715-364-2602 with questions.

Contact Information:

Participant Information:

Name_____ Birthday _____

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

E-mail: _____ Phone: _____

Primary/Emergency Contact (to be contacted in case of emergency, or if camper requires a doctor's visit, or if the camper is unable to complete the trip for any reason)

Name _____ Phones:_____, _____

Relationship to participant:_____ E-mail: _____

Second Contact or other Emergency Contact:

Name _____ Phones:_____, _____

Relationship to participant:_____ E-mail: _____

Consent:

1. In consideration with the services of Camp Amnicon and all employees and persons associated with that business (hereinafter collectively referred to as "Amnicon"), I agree as follows: Although Amnicon has taken reasonable steps to provide me with appropriate equipment and skilled guides, 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. 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 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 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 trip activities including those listed in the brochure, program information sheet, and website, except as noted. I give permission to Amnicon 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 Amnicon to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I give permission to the physician selected by Amnicon 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 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 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

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

Please include a copy of your insurance card if possible. Copy both sides of the card.

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:** Most medical conditions can be successfully managed on trail. Please note, participants with chronic medical conditions must be able to manage their condition independently, bring all necessary supplies, and have had no medical emergencies in the last year.

Has/Does the trip participant:

1. Ever been hospitalized? □ Yes □ No
2. Had surgery? □ Yes □ No
3. A recent/chronic illness/infection? □ Yes □ No
4. Any recent/chronic injury? □ Yes □ No
5. Asthma? □ Yes □ No
6. Diabetes? □ Yes □ No
7. Seizures? □ Yes □ No
8. Problematic headaches? □ Yes □ No
9. Blood pressure or heart problems? □ Yes □ No
10. Head injury or concussion? □ Yes □ No
11. Bleeding or clotting disorder? □ Yes □ No
12. Frequent ear infections? □ Yes □ No
13. Problems sleeping/sleep walking? □ Yes □ No
14. Back/joint problems? □ Yes □ No
15. Recent/chronic bowel problems? □ Yes □ No
16. Skin problems? □ Yes □ No
17. Had mononucleosis in last year? □ Yes □ No
18. If female, menstrual problems? □ Yes □ No

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:

***Diet:** □ Eats a regular diet □ Requires the following dietary accommodations: *(Describe below)*

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.

*** Medication**

□This participant will not need any special medications at camp

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

□This participant will take the following medications at camp:

Name of Medication	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:

Date of most recent tetanus immunization: _____

Have you completed the immunizations that were required for school attendance? □ Yes □ No

If the participant has not been fully immunized, please sign the following statement:
"I understand and accept the risks from not being fully immunized."

Participant/Guardian signature: _____ Date: _____

Is there anything else you think we should know? Please provide any additional information that will help us to fully care for the participant's health and well-being during their trip.

STOP!

The remainder of this form must be completed by a licensed medical professional.

This page must be completed by a licensed medical professional.

Medical Personnel: This person will attend a wilderness trip lasting up to one week involving moderate physical activity, frequent contact with water, and reduced access to advanced medical care. Please review the participant's health history and complete the remaining sections of this form. Attach additional information if necessary. With questions, please call Camp Amnicon at 715-364-2602.

Date of Most Recent Physical Exam: _____
Camp Amnicon requires a physical within the last year.

OTC Medication
The following OTC medications are stocked in Camp Amnicon's first aid kits and are given as needed to manage illness or injury. Cross out any items the participant should NOT be given.

Triple Antibiotic Ointment	Diphenhydramine (Benadryl)
Acetaminophen (Tylenol)	Bismuth Subsalicylate (Pepto Bismal)
Aspirin	Hydrocortisone 1% Cream
Ibuprofen (Advil)	Saline Eye-Wash
Phenylephrine (Sudafed PE)	Pseudophedrine (Sudafed)

Allergies □ No known allergies
□ This participant is allergic to:
- □ Food (List):
- □ Medicine (List):
- □ Environmental (List):

Describe previous reactions.

Diet/Nutrition □ Eats a regular diet □ Requires the following dietary accommodations: *(Describe below)*

Prescription Medication □ No prescribed medications □ Will take the following medication(s) at camp: (Name, Dose, Frequency—describe below)

The participant is currently undergoing treatment for the following conditions: Describe below
□ None

Does the participant require any limitations or restrictions to activity while at camp? □ Yes □ No
If yes, what do you recommend? Attach additional information if needed.

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

Name of licensed provider (please print) _____
Signature: _____ Title: _____
Office Address _____
Phone _____
Date _____