



# WILDERNESS CANOE BASE

Nurturing Christ-centered Identity Through Wilderness Experience  
• 12477 Gunflint Trail • Grand Marais, MN • 55604 •

## CAMPER/VOLUNTEER HEALTH HISTORY

### PERSONAL INFORMATION

Name: \_\_\_\_\_ M/F: \_\_\_\_\_ Age: \_\_\_\_\_  
Last First  
Home Address: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

### EMERGENCY CONTACT INFORMATION

**Custodial Parent(s)/Guardian(s)** (Please include both mother and father or guardian names)

Name(s): \_\_\_\_\_ *\*\*Please star preferred contact*

Phone (Mother) H: ( ) \_\_\_\_\_ W: ( ) \_\_\_\_\_ C: ( ) \_\_\_\_\_

Phone (Father) H: ( ) \_\_\_\_\_ W: ( ) \_\_\_\_\_ C: ( ) \_\_\_\_\_

**Emergency Contact** (if parent/guardian cannot be reached)

Name: \_\_\_\_\_ Relationship to camper: \_\_\_\_\_

Phone H: ( ) \_\_\_\_\_ W: ( ) \_\_\_\_\_ C: ( ) \_\_\_\_\_

Doctor: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ Dentist: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

### INSURANCE

Custodial parent(s) or guardian(s) of camper is financially responsible for healthcare provided by out-of-camp providers. Rx needed while at camp will be sent to camper insurance with co-pay billed to custodial parent(s) or guardian(s).

Carrier Name: \_\_\_\_\_ Group Policy #: \_\_\_\_\_

**\*\*IT IS ESSENTIAL TO SEND A COPY (FRONT AND BACK) OF CAMPER INSURANCE CARD WITH THIS DOCUMENT\*\***

### PARENTAL/PERSONAL AUTHORIZATION

My child has permission to engage in all camp activities, except as noted: \_\_\_\_\_

I authorize the camp to provide routine healthcare, administer prescribed medications and over the counter medications per camp standing orders. In the event that I/my child is injured and I cannot be reached in an emergency, I give permission to transport me/my child by camp vehicle or local ambulance and for the physician selected by the camp to secure proper treatment for, to hospitalize, and to order injection, anesthesia or surgery for me/my child as named on this form. I also authorize the release of health information paperwork for me/my child as needed in an emergency. I authorize this form to be copied for out-of-camp trips. It is the policy of this camp to contact custodial parent or guardian in the event of serious injury, severe illness or other incident involving your child. The authority for this decision is with the Healthcare staff, Site Director or Executive Director. I hereby certify that the information contained within this Health History document is, as of this date, accurate and complete.

#### Consent Authorization Signature

Custodial Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

*\*\*Registrations without this signature cannot be accepted\*\**

### MEDICATIONS **\*\*Please do not bring First Aid supplies or general over the counter (OTC) medications.\*\***

CAMPER PRESCRIPTION MEDICATIONS – Must be in original container with doctor's directions.

SPECIFIC NECESSARY OTC MEDICATIONS – Enter Information in this space also (ex. Zyrtec, chewable medications)

Medication Name	Dosage	Time Taken	Reason for Med

NOTE: Prescription medications will be returned to camper on the last day of camp session. Contact camp if this is not acceptable.

CAMP SUPPLIED OTC MEDICATIONS: Physician-approved Standing Orders allow stocking of OTC meds in Camp First Aid, these may be administered by Camp First Aid Staff as needed. Those listed below may be included in Camp Stock, please review and check those that you DO NOT want given to your child.

Acetaminophen \_\_\_\_ Antacid Tablets \_\_\_\_ Antihistamine \_\_\_\_ Cough Drops \_\_\_\_ Ibuprofen \_\_\_\_  
Sephedrine \_\_\_\_ Expectorant CF \_\_\_\_ Do not give medications to my child \_\_\_\_

### CAMPER HEALTH HISTORY – CONCERNS – CONDITIONS

(Use an additional page if additional response space is required)

#### ALLERGIES/INTOLERANCE OR DIETARY CONCERNS:

Please describe allergy, intolerance or dietary concern, along with reaction and recommended intervention.

Food or Drug Allergies: \_\_\_\_\_

Other Allergies: \_\_\_\_\_

Does Allergy lead to Anaphylactic reaction? Yes \_\_\_\_ No \_\_\_\_

If yes, detail reaction and recommended response. \_\_\_\_\_

Dietary Concerns (vegetarian, vegan, lactose intolerant, diabetic, other): \_\_\_\_\_

No special considerations required \_\_\_\_\_

#### CAMPER HEALTH HISTORY

Describe: all injuries – operations – illnesses, requiring medical attention, during current and previous calendar years. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

#### CAMPER CURRENT HEALTH

1): Describe any current conditions (injury, surgery, illness, other) that require special attention, restrictions or considerations while at camp. \_\_\_\_\_

2): Have you or are you currently receiving professional treatment to address mental/emotional health concerns? Y \_\_\_\_ N \_\_\_\_

3): Have you been exposed to a communicable disease in the past 6 months? Y \_\_\_\_ N \_\_\_\_

If yes, describe: \_\_\_\_\_

*\*If you have entered information in #1, or given a “yes” response in #2 or #3 of “Campers Current Health” you must have the following section completed by your attending health professional\**

#### PHYSICIAN’S RECOMMENDATIONS \*\*Must be completed & signed by medical personnel\*\*

The camper named on this Health History is/has been under my care for the following: \_\_\_\_\_

Is this camper able to participate in an active camp program? Yes \_\_\_\_ No \_\_\_\_ Detail (no) response, listing restrictions: \_\_\_\_\_

Detail treatments to be continued while at camp: \_\_\_\_\_

If camper has been exposed to contagious disease, is period of contagion over? Yes \_\_\_\_ No \_\_\_\_

Signature of Licensed Medical Personnel \_\_\_\_\_ Date \_\_\_\_\_

### IMMUNIZATION HISTORY

Are you/is your child current on the following immunizations:

Hepatitis B, DTP, MMR: Mumps, Measles, Rubella? Yes \_\_\_\_ No \_\_\_\_ Date of last Tetanus: \_\_\_\_\_

List exceptions: \_\_\_\_\_

### CONFIDENTIALITY STATEMENT

Information within this Health History document is considered CONFIDENTIAL; the information will only be shared on a “need to know” basis.