

WHC reserves the right to refuse admission to any person whose health form is not on file 2 weeks before their camp begins.

Health Form: Windsor Hills Camp 2010

29 White Pond Road, Windsor, NH 03244 voice (603)478-3363 fax (603)478-3373

This form is confidential to camp counselors, camp directors, health personnel and the registrar.

Mail to: Registrar, Rick Smith, 29 White Pond Rd., Windsor NH 03244

Campers, workers and staff are required to submit a new health form each year. A qualified physician's signature must appear on each camper's health form to comply with New Hampshire State law. The "Date of Exam" must be less than 2 years prior to the camp date. Please send Health Form to Registrar **at least 2 weeks prior to camp date.**

Important: You may not stay overnight on the campground until we have received a *completed Health Information Form.*

Applicant's name _____ Social Security # _____ DOB _____

Address _____ City _____ State _____ Zip _____

Circle ALL Windsor Hills Camps that you will be attending in 2010: Parent email: _____

Family Camp Boys' Camp Girls' Camp Jr. High Camp Sr. High Camp

INSURANCE INFO: Subscriber's name _____ Birthdate _____ Policy # _____

Insurance company name _____ Phone () _____

IN CASE OF EMERGENCY NOTIFY: (For children at least one must be a parent or legal guardian.)

Name _____ Relationship _____ Phone H () _____ W ()

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In case of emergency, **I HEREBY GIVE PERMISSION** to the physician selected by Windsor Hills to hospitalize, secure proper treatment for, or to order injections, anesthesia or surgery for applicant. (Every effort will be made to contact parents or legal guardian.) I accept responsibility for payment of all expenses incurred as a result of medical treatment.

SIGNATURE of parent or guardian if a minor. X _____ Date

Or

SIGNATURE of applicant if over 18 years old. X _____ Date

BELOW TO BE FILLED OUT BY PHYSICIAN

Record of immunizations (**Required DATES of latest boosters.**) You may attach a printout of immunization record and report of physical from physician's office but **we still require doctor's signature or stamp.**

DPT (date)	Oral Polio (Sabin) (date)	Rubella (date)	Hepatitis B (date) (if born on or after Jan 1, 1993)
DT (date)	MMR (date)	Mumps (date)	
Tetanus (date)	Measles (date)		

Treatment or medication to be continued at camp:

Special medication precautions or special medical concerns for camp staff, camp doctors or nurse to be aware of for this applicant in a camp setting:

Allergies: _____ **For severe allergies / medical concerns, continue on back and check here**

Special diet requirements: _____ Restrictions on activity while at camp:

Date of exam _____ Physician's name _____ Phone (____)

Doctor's Address _____ City _____ State _____ Zip

SIGNATURE OF PHYSICIAN or OFFICE STAMP X _____ Date

If Doctor's form is substituted, be sure permission to treat is signed and exam date is noted. These areas are legally essential!!

Last name, First

Additional Optional Information

If your child has a severe life-threatening allergy, you must call the campground to personally register that information. Call Rick Smith at 603-478-1450

Please describe allergies to food:

Please describe allergies to medications:

Please describe any other allergies:

Are there specific health concerns you have for your child?

Is your child recovering from a recent illness? If so, please describe the incident, carefully noting any limitations this might create for your child.

According to past experiences, is your child prone to homesickness? Please offer advice:

Are there telephone numbers of additional health professionals that we should have in the event that your child needs their treatment? Please list:

Anything else you want the nurse to know?