CAMP HEALTH EXAMINATION FORM

Developed by the American Camping Association in consultation with The American Medical Association and the American Academy of Pediatrics

Name:____ **Birth date:** __________**Gender: M:**___**F:**___ **Age:**_____
Last First M. Init.

Name of Parents/Guardians (or spouse): ____**Phone:** ______________________

Home Address:____
Street City State Zip

Email Address:____

Church/Organization: ____

If not available in an emergency please notify:

1. ____Phone: ________________
   Name Relationship
2. ____Phone: ________________
   Name Relationship

Check all that apply, giving approximate dates

Health History	Date	Allergies	Date	Diseases	Date
____ Frequent Ear Infections	________	____ Hay Fever	________	____ Chicken Pox	________
____ Heart Defect/Disease	________	____ Poison Ivy, etc.	________	____ Measles	________
____ Convulsions	________	____ Insect Stings	________	____ German Measles	________
____ Diabetes	________	____ Penicillin	________	____ Mumps	________
____ Bleeding/Clotting Disorders	________	____ Other Drugs	________	____ Asthma	________

Allergies (describe reactions/treatment):
____

Operations or serious injuries and dates:
____

Chronic or recurring illnesses:
____

Dentist/Orthodontist: ____Phone: __________________
Family Doctor: ____ Phone: __________________
Medical/Health Insurance Company:___________________________________**Policy or Group #:**________________

IMPORTANT: *Please notify us if this individual is exposed to any communicable disease during the three weeks prior to attending.*

Medications: ***All medications must be in original pill bottles!***

Medication 1:____________________ Dosage:________________ Administer at: ☐breakfast ☐ lunch (Check all that apply) ☐dinner ☐ bed ☐ other Reactions:________

Physician:____________________ RX#:________________ Route of Administration:________________ Date:__________

Medication 2:____________________ Dosage:________________ Administer at: ☐breakfast ☐ lunch (Check all that apply) ☐dinner ☐ bed ☐ other Reactions:________

Physician:____________________ RX#:________________ Route of Administration:________________ Date:__________

(If more medications are necessary please use the back of this form)

IMPORTANT: MUST BE COMPLETED FOR ATTENDANCE

Parental Authorization. This health history is correct so far as I know, and the person described herein has permission to engage in all prescribed activities. In the event of an emergency, I hereby give permission to the physician selected by the Expeditions Unlimited staff to order X-rays, routine tests and treatment for the health of my child. In the event that I cannot be reached in an emergency, I also give permission to the physician selected by the Expeditions Unlimited staff to hospitalize, secure proper treatment for, to order injection and/or anesthesia and/or surgery for my child as named above.

Parental Signature:____ **Date:**____________________

Release of Claims and Waiver of Liability

The undersigned applicant acknowledges, understands and agrees that as to the contemplated trip with Expeditions Unlimited:

1. There are unique physical demands and risks involved;
2. The activity can be of a dangerous nature which can result in serious and potentially fatal injury;
3. That instructions given must be followed for ongoing participation and safety of the applicant; and
4. That Expeditions Unlimited, Ltd. retains the right of final approval of all participants and the right to terminate a participant's involvement in a trip at its discretion.
5. The Expeditions Warrior Challenge is an optional activity entailing unique physical demands and risks which may result in injury including but not limited to, dislocations, broken bones, lacerations, abrasions, bruising, strains, sprains, paralysis, or death.

In consideration of conducting the trip and based on the above, Expeditions Unlimited, Ltd., it's officers, directors, employees, agents and their heirs, executors and assigns are released as to any and all claims for damages, including but not limited to injuries, whether to person or property, known or unknown that the undersigned has or may have in the future arising out of and in connection with the contemplated trip.

Release as to Photographic, Movie and Video Images
The undersigned irrevocably consents to and authorizes the use and reproduction of any and all photographic and video images taken during the contemplated trip. The use and reproduction of images is at the discretion of Expeditions Unlimited whether for advertising, promotional or other legal purposes without additional consideration or compensation to the undersigned. Originals and copies or images are and will remain the sole property of Expeditions Unlimited, Ltd.

Applicant Information
Complete the following information for each member of your household participating in the trip with Expeditions Unlimited.

Name(s)	Applicant's Signature — Date of Birth
Address	Applicant's Signature — Date of Birth
City — State — Zip	Applicant's Signature — Date of Birth
	Applicant's Signature — Date of Birth
	Applicant's Signature — Date of Birth

Parent or Guardian Signature ____Date____/____/____
*Required if applicant is under 18 years of age

Telephone (608) 356-4004
Fax (608) 356-4185

Food Allergy Action Plan

*Completion of this form is necessary **only** if participant has a food allergy*

Name: ____

Group: ____

Allergy To: ☐ Dairy ☐ Wheat ☐ Eggs ☐ Peanuts ☐ Tree Nuts ☐ Other: (Please list)

____

(We do not provide specialized meals for vegetarians, vegans, or other lifestyle choices. If you have a food allergy, we will do our best to accommodate your needs)

Physician:____Phone #:_____________________

Emergency Numbers
Name: ____Phone #: _____________________

Name: ____Phone #: __________________

PLEASE TELL US WHAT TO DO IN CASE OF AN ALLERGIC REACTION

CHECK ALL THAT APPLY

This Occurs:
My Child's allergic reaction includes:

- ☐ Swelling, itching raised skin rash
- ☐ Generalized body flush, swelling or itching
- ☐ Nausea, abdominal cramps, vomiting and/or diarrhea
- ☐ Itching and swelling of lips, throat, or tongue causing hoarseness, swallowing difficulty, coughing, wheezing or shortness of breath.
- ☐ "Thready" pulse, "passing out"
  - These signs may occur
    - ☐ Within a few minutes
    - ☐ Within 30 minutes to 2 hours

The severity of symptoms can quickly change. All above symptoms can potentially progress to a life-threatening situation.

General First Aid

- Observe for 30 minutes
- Notify Parents
- ☐ Administer oral medication And
  Name ___________ ___________
  Dosage __________ ___________
- ☐ Administer adrenaline (Epi Pen)
  - ☐ Immediately
- ☐ If symptoms occur (describe)

Student can self-administer Epi Pen? Yes No

If Epi pen is administered, an ambulance, then parents will be notified

** ***Please Note**: Expeditions Unlimited **cannot** provide specialized meals for participants but we can provide a couple of additional options, as well as inform students of the ingredients found in prepared food.*

Please return this form **2 weeks** prior to scheduled arrival date.

If returned later than **2 weeks** additional options may not be available.

Comments regarding other accommodations: ____

Parental Signature: ____Date: __________________