11 Center Street, P.O. Box 6243, Rutland, Vermont 05701
802-282-2678, info@wkmvt.org, www.wonderfeetkidsmuseum.org

Camp Participant Medical Form

This medical form must be completed and signed by a parent/guardian. Please return no later than two weeks before the start of camp. Participants will not be allowed to attend without this completed form.

PARTICIPANT'S NAME:_____

DATE OF BIRTH: _____ SEX: ___M ___F HEIGHT:_____ WEIGHT:_____

Has the participant been treated for any medical problems in the following areas?

Seizures_____ Length of seizure_____

Cardio Vascular_____ Restrictions_____

Orthopedic Observations_____ Restrictions_____

Pulmonary_____ Restrictions_____

Asthma?_____ _____ Medications?_____ Inhaler?_____

Any limitations with sight or hearing? Does the participant wear corrective lenses?

_____

Does the participant have any contagious or infectious diseases?_____ If yes, explain_____

_____

Has the participant been exposed to any contagious or infectious diseases in last 6 months?_____ Be specific:

_____

ALLERGIES: Has the participant had any allergic reactions to the following (be specific) - If so, list in detail the reaction:

Drugs:_____ Reaction:_____

Insect Bites:_____ Reaction:_____

Foods:_____ Reaction:_____

Other:_____ Reaction:_____

Other:_____ Reaction:_____

Does the participant need to carry an epinephrine pen for any allergies? ___Yes ___No

If yes, which allergy? _____

MEDICATION: Please list all medication the participant is currently taking (or attach a current medication schedule for this person):
MEDICATION DOSAGE SCHEDULE

1. _____

2. _____

3. _____

4. _____

Please describe any other conditions about which program staff should be aware, including social and/or emotional needs:

_____

_____

_____

DATE OF MOST RECENT EXAM:_____NOTE: Most recent exam must be within last two years.)

PHYSICIAN'S NAME (please print):_____ _____

Complete Address: _____

Phone:_____ _____

MEDICAL TREATMENT
I give Wonderfeet Camp staff consent to make decisions about_____(participant's name) immediate medical care and, if necessary, either take him/her or arrange for him/her to be taken (by Emergency Medical Services) to the nearest emergency room to receive emergency medical treatment. I give permission to the medical personnel selected by Wonderfeet Camp staff to provide routine health care; to administer x-rays, routine tests and treatment; to release any records necessary for insurance or treatment purposes; and to provide or arrange necessary transportation for my child or ward. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Wonderfeet Camp staff to secure and administer treatment, including hospitalization, for my dependent.

Parent/Guardian Signature: _____ ***Date:*** _____