PERFORMANCE AS EDUCATION

Participant Health Form

Mail this form

to the address below by JUNE 7, 2013

Amy Poirier
PO Box 641066
Pullman, WA 99164-1066

Participant Name: _____
First Middle Last

Attendance Dates: from:_____ to _____

☐ Male ☐ Female Birth Date_____ Age on arrival at camp: _____
Mont/Day/Year

***To Parent(s)/Guardian(s)*: Please follow the instructions below. Attach additional information if needed.**

1. ***Complete pages 1 and 2 of this form (and make a copy for yourself).***
2. ***Send the original, signed form to camp by requested date.***

Participant Home Address: _____
Street Address City State Zip Code

Parent/guardian with residential placement and/or decision-making authority in the event of illness or injury:

Name:_____ Relationship to Participant: _____

Preferred Phones: (_____)_____ (_____)_____ Email: _____

Home Address: _____
(If different from above) Street Address City State Zip Code

Second parent/guardian with legal responsibility/authority to be contacted in case of illness or injury:

Name:_____ Relationship to Participant: _____

Preferred Phones: (_____)_____ (_____)_____ Email: _____

Additional parent/guardian to be contacted in case of illness or injury:

Name:_____ Relationship to Participant: _____ Preferred Phones: (

Allergies: ☐ No known allergies. ☐ This participant is allergic to: ☐ Food ☐Medicine ☐The environment (insect stings, hay fever, etc.) ☐ Other
(Please describe below what the participant is allergic to and the reaction seen, in detail. Please describe preventative or responsive measures.)

☐ **This participant has a life-threatening allergy. An emergency care plan signed by physician is required.**

Diet, Nutrition: ☐ This participant eats a regular diet. ☐This participant eats a vegetarian diet (describe details below).
☐ This participant has special food needs. ***(Please describe below.)***

Immunizations:

☐ My child is up-to-date on his/her immunizations and tetanus shots as required by Washington State law.

☐ My child has an immunization exemption on file with his/her school. I understand and accept the risks to my child from not being fully immunized.

Restrictions:

☐ I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.
☐ I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations.
(Please describe below.)

General Health Information :

NOTE: It is strongly recommended that parents/legal guardians consult a physician prior to allowing their child to participate in physical activity.

Are there any medical concerns which the camp staff should be aware of? ***Attach additional information if needed.***

Camper Name: _____ _____ _____
First Middle Last

(For Camp Use) Cabin or Group _____

(For Camp Use) Session Code(s) _____

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Participant Name: _____
First Middle Last

Birth Date: _____
Month/Day/Year

Medication:

Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. **All medications must be in their original containers. Prescriptions must have the child's name and how the medication should be given printed on the prescription container. Please send only those medications that are necessary. All medication will be stored under the controlled possession of the staff.**

☐ This participant will not take any daily medications while attending the activities.

☐ This participant will take the following daily medication(s) while attending the activities.[1]

Name of medication	Date started	Reason for Taking	When it is given	Amount or dose given	How it is given
			☐ Breakfast ☐ Lunch ☐ Dinner Other time: _____		
			☐ Breakfast ☐ Lunch ☐ Dinner Other time: _____		
			☐ Breakfast ☐ Lunch ☐ Dinner Other time: _____		

Comments:

Does the participant require reasonable accommodation for a disability in order to access or be part of the activities?

What Have We Forgotten to Ask? ***Please provide in the space below*** any additional information about the participant that you think important or that may affect his or her ability to fully participate in the program. ***Attach additional information if needed.***

This health history is correct and accurately reflects the health status of the participant to whom it pertains. The person described has permission to participate in all program activities except as set forth by me and/or an examining physician. If you fail to advise WSU of a medical condition, risks to your child may increase. I understand the information on this form will be shared on a "need to know" basis with WSU staff and volunteers. I give permission to photocopy this form. In addition, the health care provider has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status

Signature of Primary Residential Parent _____ Parent/Guardian:

_____ Relationship to Participant: _____

Date: _____

Parent/Guardians: Keep a copy for your records.

[1] Note: These provisions regarding administration of medication shall not abrogate minors' rights to provide their own consent to certain services under Washington law.

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For Camp Use Only

Participant Name: _____
First Middle Last

Birth Date: _____
Month/Day/Year

Individual Health Record

Initial Screening **Date/Time:**_____ **Initials:**_____

NOTES: (Provide Date/Time/Initial All Entries)

Medication: (Provide date/time/type of medication/amount/initial all entries)

Exit Note: Check one of the following:

☐ Left camp this day with no reported illness or injury symptoms.

☐ Left camp this day with the following problem/concern:

Date/Time:_____Initials: _____