HUNT HILL AUDUBON SANCTUARY MEDICAL FORM - YOUTH

DATE(S) OF PROGRAM(S) ATTENDING:_____
CAMPER'S FULL NAME:_____
Street, City, State, Zip:_____
PHONE: (H) _____(C)_____(W)_____
DATE OF BIRTH:_____ AGE: _____
Our camp provides first aid only. In the event of illness, or injury, a doctor will be called at the participant's expense.
In an emergency, the camper will be transported to Spooner Memorial Hospital, unless preference is noted here:
_____

In case of emergency, who should be notified?
NAME: _____ RELATIONSHIP:_____
STREET: _____ PHONE: (H) _____
CITY: _____STATE___ZIP_____ (C) _____(W)_____
FAMILY DR: _____CLINIC_____
ADDRESS_____PHONE_____

HEALTH CONDITIONS AND ALLERGIES
Are activities in any way limited now?_____
Has the camper been ill recently? _____With what? _____
Is camper allergic to any medication? (specify) _____
_____
Is camper allergic to any insects or plants? _____
Is the camper currently taking any medication? _____
_____
Date last tetanus booster: _____

DIETARY NEEDS AND FOOD ALLERGIES
List special dietary needs or food allergies: (Please review our Special Dietary Policy for more information and possible meal surcharges.)_____

PAST MEDICAL HISTORY
Any history of asthma or severe allergic reaction? _____
Previous surgery? _____
Previous severe injuries (broken bones – major trauma)? _____
Previous hospitalization? _____
Any issues requiring regular medical attention? _____

INFORMED CONSENT WITH APPROVAL TO GIVE:
EPINEPHRINE (EPI-PEN® OR EPI-PEN JR®) ____☐__ DIPHENHYDRAMINE (BENADRYL®) ____☐___
ACETAMINOPHEN (CHILDREN'S TYLENOL) ____☐__ IBUPROFEN (MOTRIN® or ADVIL®) ____☐__
*Epinephrine and/or diphenhydramine may be administered for the management of an allergic reaction with the **in**tent to improve recovery and to reduce the incidence of disability. Over-the-counter acetaminophen and/or ibuprofen may be administered for the management of pain.*

By signing below, I certify that all information above is accurate and correct. In addition, I give my consent forHunt Hill staff to administer the medication/s that I have approved under the informed consent portion of this form.
Guardian Printed Name: _____

Signature: _____Date_____

**Please fill out one medical form PER camper.