Woodland Ways, PO Box 228, Philmont, NY. 12565-0228. (518) 542-9081 woodlandways@woodlandways.com

Woodland Ways
Medical Information and Release Form

This confidential information will only be made available to medical personnel only in case of injury or illness while participating in Woodland Ways Programs. **This form must be filled out prior to attending the program.**

Students Name_____Age_____

Address_____Phone_____

City_____State_____Zip_____

Emergency Contact_____Phone_____

Are you allergic to any medication, and if so, which ones? _____

_____

List all allergies to foods or insect bites/stings_____

_____

If allergic, do you have your own Epi pen?_____

Will you be taking medication while at camp?_____

If yes please give a complete list with instructions, of all medication._____

I understand that my child will be participating/engaging in potentially life threatening and dangerous activities during the program. My child does not suffer from any medical condition, ailment or other condition which could in any way limit their ability to participate in the activities required by the program. I hereby assume full responsibility for all risks which may be associated with , and all injuries which may occur to them in connection with, their participation in the program. I hereby release and hold harmless Woodland Ways, its agents, and others working for it or on its behalf, from and against any and all claims, liabilities, injuries or accidents including, without limitation, any claims for personal injuries and any claims based on any negligent acts, omissions, or other fault on the part of any of the parties connected with, their participation in the program.

I, the undersigned, authorize Woodland Ways staff, on behalf of my child, to obtain medical treatment by licensed physicians and the performance of emergency first aid treatment services relative to injuries or illness arising during participation of a Woodland Ways program by certified emergency and healthcare providers.

I hereby release to Woodland Ways, rights to use any photograph or video with audio, taken of said student while participating in any Woodland Ways program, to be used as deemed by Woodland Ways, including advertising. I represent and warrant that I am over eighteen years of age and a legal guardian of above named student.

* _____ * _____ _____

Parent/Guardian. Print Name | Signature | Date

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General Questions to be completed by parent or guardian.

Please answer yes or no to each question, and explain all "yes" answers below.

Has/does the participant :

1. Had any recent injury, illness or infectious disease?_____
2. Have chronic or recurring illness/ condition?____
3. Ever been hospitalized?_____
4. Ever had surgery?_____
5. Have frequent headaches?_____
6. Ever had a head injury?_____
7. Ever been knocked unconscious?_____
8. Wear glasses, contacts or protective lenses?____
9. Ever had frequent ear infections?_____
10. Ever passed out during or after exercise?____
11. Ever been dizzy during or after exercise?
12. Ever had seizures?_____
13. Ever had chest pain during or after exercise?_
14. Ever had high blood pressure?_____
15. Ever been diagnosed with a heart murmur?_____
16. Ever had a back problem?_____
17. Ever had problems with joints (knees, ankles)?_____
18. Have an orthodontic appliance being brought to camp?_____
19. Have any skin problems (itching, rash, severe acne)?_____
20. Have diabetes?_____
21. Have asthma?_____
22. Had mononucleosis in the past 12 months__
23. Had problems with diarrhea or constipation? ____
24. Have problems with sleepwalking?_____
25. If female, have abnormal menstrual history?___
26. Have a history of bed-wetting?_____
27. Ever had an eating disorder?_____
28. Ever had emotional difficulties for which professional help was sought?_____

Please explain any "yes" answers, noting the number of each question you are answering.

Is the participant currently under the care of a physician for any conditions? If so, please describe the condition and treatment.

Does this condition require any special care or treatment while the student is at camp? If so, describe bellow.

Please include all health insurance information. In the event a doctors visit is required, Woodland Ways insurance will cover the deductible as well as anything over your coverage limit. If you currently have no insurance, your child will be covered by the Woodland Ways policy.

Insurer: Policy No.

Woodland Ways Health Record

Name of Student_____DOB_____

To be Completed by Physician

Height: ft in
Weight: lbs
Pulse:_____
BP: /
Neuro-psych:
Lungs:
ENT:

Skin:
Spine:
Abdomen:
Neck:
Heart:
Head Lice:
Extr:

Recommendations/Restrictions_____

_____

Immunization Records

Type	Date	Date	Date	Date
Haemophilus Influenza Type B				
Hep. B				
MMR				
DTP				
Td/Dt/T				
OPV				
Vericella				

Which of the following has the applicant had? (circle all that apply)

Measles Chicken Pox German Measles Mumps Hepatitis

This completed form *signed* by your physician shall serve as the ***Physicians Certificate*** of such immunizations as required by Public Health Law, Title VI-Section 2164.

If claiming religious exemption from immunizations please include your statement.

Physicians Name Date

Physicians Signature Date

Address Phone