UNIVERSITY OF MAINE & UNIVERSITY OF ILLINOIS at URBANA-CHAMPAIGN

WHIMC Spring Camp, 2024

EMERGENCY CONTACT and MEDICAL INFORMATION

Please choose one of the following methods to return this form.

- ❏ email to bryce.roix@maine.edu
- ❏ bring it on the first day of the camp

CAMPER INFORMATION:

NAME:_____

ADDRESS:

_____

Number / Street *City* *State* *Zip Code*

AGE: _____GENDER:_____DATE OF BIRTH:_____/_____/_____

PARENT/GUARDIAN/OTHER:

NAME: _____

RELATIONSHIP: _____ ADDRESS:

_____

Number / Street *City* *State* *Zip Code*

DAYTIME PHONE:( )_____ MOBILE PHONE:( )_____

EMERGENCY CONTACT:

NAME: _____RELATIONSHIP: _____

ADDRESS:

_____

Number / Street *City* *State* *Zip Code*

DAYTIME PHONE:( )_____ MOBILE PHONE:( )_____

HEALTH INFORMATION STATEMENT (OPTIONAL):

Check below and provide any information you feel the staff may need to maximize the safety and the well-being of the attendee. To the right of the condition statement is space for more information relating to the condition checked. Please be specific. In case of emergency, this health information may be the only source of accurate important information. This information is confidential.

[ ] Nervous or Mental (epilepsy, emotional stress, convulsion)

_____

_____

[ ] Lung Disease (asthma, persistent cough, tuberculosis) _____

_____

[ ] Hay Fever or Allergies _____

[ ] Allergy to Medicines (including penicillin, tetanus) _____
[ ] Impaired Sight or Hearing, Chronic Ear Infections _____
[ ] Recent Surgical Operations, Accidents or Injuries _____
[ ] Skin Disease _____
[ ] Allergy to Foods
_____

[ ] Does the Camper Wear Glasses? YES [ ] NO [ ] SOMETIMES [ ]
[ ] Does the Camper Wear Contact Lenses? YES [ ] NO [ ]
[ ] Date of last TETANUS BOOSTER _____
[ ] Other conditions program staff should be aware of _____
_____
_____

INSURANCE INFORMATION (OPTIONAL):

DOCTOR'S NAME: _____
CLINIC/HOSPITAL NAME: _____
CITY/STATE: _____PHONE: ( )_____

HEALTH INSURANCE PROVIDER:
Name: _____
Address:
_____

City / State Zip Code
NAME OF POLICY HOLDER:_____DATE OF BIRTH:_____/____/_____
POLICY NUMBER: _____

_____As a parent or guardian, I understand that if a serious illness/injury develops, medical or hospital care will be besought. I further understand that in case of serious illness/injury, I will be notified. However, if it is impossible to contact me, I give my permission for medical treatment, as recommended by an attending physician.
_____I approve the release of medical information to WHIMC Staff and any treating physician.
_____I approve the release of insurance information to the health care provider (doctor, hospital of my child).
_____I approve the health care provider to release information to the insurance company.
_____I approve benefits from my insurance are payable to the health care provider.
_____If the benefits are paid directly to me, I will pay the health care provider.
_____I verify the above information is correct to the best of my knowledge.
_____My signature verifies the above information to be correct to the best of my knowledge.

SIGNATURE: _____DATE:_____
(Parent or Guardian)
Parents/Guardians must complete and sign this form in order to finalize a camper's registration and allow participation in camp activities. A doctor's physical exam is not necessary-- general medical information is helpful, only contact information is required.