



HEALTH INFORMATION & RELEASE FORM

Please follow the instructions below and attach additional information if needed.

Complete ALL pages of this form and send the original, signed form to Wolf Ridge at least 2 weeks in advance.

NAME OF PARTICIPANT: _____

AGE (on arrival at camp): _____ **BIRTHDATE:** _____ **ENTERING GRADE:** _____ **GENDER:** _____

DATES OF SESSION _____

SESSION CAMPER WILL ATTEND (circle one)

Summer Sampler	BWCAW Canoe
Discoverers	Apostle Islands Kayak
Voyagers	Camp Rock Climbing
Voyagers 2 wk - Ultimate Survival	Isle Royale Kayak Expedition
Adventurers 1-wk	Camp Fish
Adventurers 2 wk Isle Royale	Angling to Archery
Adventurers 2 wk BWCAW Canoe	Adventurers Farm Camp
Jr. Nats 2 wk Quetico Canoe	Voyageur Harvesters Farm Camp
Jr. Nats 2 wk Apostle Is. Kayak	Counselor in Training (CIT)
Credit Academy: Freshwater Eco.	S.E.A.K / Murray e2 Program
Credit Academy: Wilderness Ethics	Duluth YMCA Program
Day Camp	

ETHNICITY/RACE please check all that apply

Black/Afro-Caribbean/African American
Any person having origins in any of the black racial groups of Africa.

Latino(a)/Hispanic American
A person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin

Asian/Asian American
A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Phillipine Islands, Thailand and Vietnam

American Indian/Alaskan Native
A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment

Non-Hispanic White/Euro-American

Prefer not to answer

SCHOOL INFORMATION

Name of School: _____

City/State of School: _____

T-SHIRT SIZE youth & adult sizes, please circle one

Y-Small Y-Medium Y-Large A-Small A-Medium A-Large A-XL

CAMPER HOME ADDRESS

Street Address City State Zip

Parents/Guardians with legal custody to be contacted in case of an emergency

Name: _____ Relationship to Camper: _____ Preferred Phones: () _____

Name: _____ Relationship to Camper: _____ Preferred Phones: () _____

Additional contact in the event parents/guardians can not be reached

Name: _____ Relationship to Camper: _____ Preferred Phones: () _____

Name: _____ Relationship to Camper: _____ Preferred Phones: () _____

Home
 Work
 Mobile

Home
 Work
 Mobile

Home
 Work
 Mobile

ALLERGIES (please check)

No Known Allergies

Camper is allergic to Food Medicine Environmental (insects, hay fever, etc) Other

(Please describe below what exactly the camper is allergic to and the reaction seen)

DIET & NUTRITION (please check)

- This camper has an unrestricted diet
 This camper has a gluten free diet

- This camper has a regular vegetarian diet
 This camper has other dietary needs (please describe below)

Please note, Wolf Ridge cannot accommodate 100% vegan diets. You will need to supplement meals with food brought from home. Read the Welcome Packet for more information on meals and dietary concerns.

NON - PRESCRIPTION MEDICATIONS

The following non-prescription medications are stocked in the health room. They are used on an as needed basis to manage illness and injury. Please CROSS OUT those which should NOT be given by Wolf Ridge staff. All medications are administered by the guidelines listed on the packaging.

Acetaminophen (Tylenol)
 Ibuprofen (Advil)
 Diphenhydramine antihistamine (Benadryl)
 Triple Antibiotic ointment
 Loperamide HCL (Imodium)
 Bismuth tablets (Pepto-Bismol)

Loratadine (Claritin)
 Calamine Lotion
 Pseudoephedrine decongestant (Sudafed)
 Phenylephrine decongestant (Sudafed PE)
 Guaifenesin cough syrup (Robitussin)
 Aloe

Antacids
 Cortaid
 Dimetapp
 Insect Repellent
 Sunscreen/Sunblock

PRESCRIPTION MEDICATIONS

Please list ALL medications taken routinely. Bring enough medication to last the entire program. Keep it in the original packaging/bottle that identifies the prescribing physician, the name of the medication, the dosage, and the frequency of administration. Medication is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies.

- This person takes NO medications during their time at Wolf Ridge
 This person takes medications as follows (Please indicate the Medication, Dosage, Frequency and Reason) Use extra sheets if necessary

Name of Medication	Reason for taking it	Time medication is given	Amount or dose	How it is given
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other _____		
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other _____		
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other _____		
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other _____		

EMOTIONAL/BEHAVIORAL HEALTH HISTORY

Please check yes or no to the following questions and provide a brief description of the ones checked yes. Attached extra sheets if necessary

- YES NO**
1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?
2. During the past 12 months seen a professional to address mental/emotional/behavioral concerns?
3. Had a significant life event that continues to affect the campers life? (i.e. death in the family, family changes, new sibling, natural disaster, etc)
4. Other _____

PHYSICAL HEALTH HISTORY

Please check yes or no to the following questions and provide a brief description of the ones checked yes. Attached extra sheets if necessary

YES NO

1. Ever been hospitalized?
2. Ever had surgery?
3. Have recurrent/chronic illnesses?
4. Had lice?
5. Had a recent injury?
6. Had asthma/wheezing/shortness of breath?
7. Have diabetes?
8. Had seizures?
9. Had headaches?
10. Had high blood pressure?
11. Wear glasses, contacts, or protective eyewear?
12. Had fainting or dizziness?
13. Passed out/had chest pain during exercise?

YES NO

14. Had racing of your heart or skipped beats?
15. Had mononucleosis during the past 12 months?
16. Have problems with falling asleep/sleepwalking?
17. Have a history of bedwetting?
18. Ever had back/joint problems?
19. Have problems with diarrhea/constipation?
20. Have any skin problems?
21. Motion sickness?
22. Had a recent infectious disease? (if you checked yes, please check appropriate diseases below)
- Chicken Pox
 - Meningococcal Meningitis
 - Hepatitis A
 - Hepatitis B
 - Hepatitis C
 - Measels
 - Mono (within the past year)

VACCINATIONS & IMMUNIZATIONS

Please list the date of your child' most recent vaccination or booster, if any, for the following concerns;

Name of Vaccination	Is Vaccinated for this Concern	Date received
TB	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Diphtheria, Pertussis, Tetanus, Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Haemophilus Influenza B	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hep A	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hep B	<input type="checkbox"/> Yes <input type="checkbox"/> No	
HPV	<input type="checkbox"/> Yes <input type="checkbox"/> No	
IPV/OPV	<input type="checkbox"/> Yes <input type="checkbox"/> No	
MMR	<input type="checkbox"/> Yes <input type="checkbox"/> No	
PCV	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Meningococcal Meningitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	

ADDITIONAL INFORMATION

Please use the space below to provide any additional information you believe would be important for Wolf Ridge to know prior to your child attending camp.

INSURANCE & EMERGENCY BILLING INFORMATION

There is no charge for basic first aid care given at Wolf Ridge by staff members of Wolf Ridge. However, parents/guardians are financially responsible for health care given by other health care providers such as clinics and hospitals. Please provide the following information for use in case of emergency. Include a copy of your insurance card if appropriate.

This camper is covered by medical insurance Yes No

Name of Insurance Company: _____ Policy Holder's Name: _____

Group #: _____ Policy #: _____

Physician: _____ Phone: _____

CAMPER PICK-UP INFORMATION

For safety reasons, we will be confirming that the person picking up this camper is the person listed below by asking for identification (such as a driver's license). If this changes, please provide changes in writing by e-mailing updated information to mail@wolf-ridge.org

Who will be picking up your camper on the last day of the session? If unsure, please e-mail updated pick up information to mail@wolf-ridge.org. Include campers name and session in the email.

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

ASSUMPTION OF RISK & RELEASE

Please read and sign below. Signature required for camper participation.

As a parent/guardian of the above named child in the youth program at Wolf Ridge ELC, I acknowledge and am aware that this program involves certain inherent risks, which I accept. These risks may include injuries relating to, but not limited to, walking on uneven trails with elevation gains of up to 500 feet in various weather conditions, canoeing (spring, summer and fall), cross country skiing and snowshoeing (winter), rock climbing and belaying, overnight camp, being transported by vehicles to activities, kayaking, hiking, field games, participating in a high ropes course activity, weather and other peoples' actions. Following appropriate medical consultation, I hereby certify that my child is fully capable of participating in the activities.

In the event of an emergency, I authorize treatment by Wolf Ridge staff, and emergency medical personnel. I give my permission for the prescription and non-prescription medications listed in the medical information section of this form to be administered by designated Wolf Ridge staff. I understand that I am financially responsible for all medical charges incurred on behalf of my dependents or myself. I authorize the health care provider to release all information needed to secure payment of benefits, and I authorize the use of this signature on all insurance claims for myself and/or my dependent.

Accordingly, I hereby release Wolf Ridge ELC, including all of their personnel, agents, affiliates, staff and directors, from any and all claims and liabilities with respect to injury, sickness, disease, loss or damage sustained by the above named child. This release applies to any and all liabilities to my estate, of any description, or me whether arising from ordinary negligence or otherwise, and whether involving fees and expenses of any kind. In the event that some other person or entity seeks compensation for these released liabilities, my estate, or I will indemnify and hold harmless the above noted group and Wolf Ridge ELC for all sums incurred in response to that claim. This release is to be interpreted and enforced under Minnesota law.

I authorize Wolf Ridge ELC to use any photos and videos taken and comments made on evaluations during the visit to Wolf Ridge in publicity materials for Wolf Ridge ELC. The information I have provided on this sheet is complete and correct.

PARENT/GUARDIAN SIGNATURE _____ DATE _____

Please complete this form and mail it back to Wolf Ridge 2 weeks prior to your child's session.

Mail to
Wolf Ridge ELC
6282 Cranberry Road
Finland, MN 55603

Fax or
email
mail@wolf-ridge.org
218-353-7762