

# Summer Camp Health Form

Camp Name/Date(s): \_\_\_\_\_

The health form is kept confidential and used by our health services staff (or emergency medical personnel). **Every camper needs a completed health form to participate in any summer camp programs. Please fill out this form as completely as possible.** Thank you!

## SECTION I – BASIC CONTACT INFORMATION

Camper Name \_\_\_\_\_

Birth date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age \_\_\_\_\_ Gender  Male  Female

Home Address \_\_\_\_\_

Home Phone \_\_\_\_\_

Parent/Guardian #1 Name \_\_\_\_\_

Relationship: \_\_\_\_\_

Day Phone \_\_\_\_\_ Night Phone \_\_\_\_\_

Day Phone is  Home  Work  Cell Night Phone is  Home  Work  Cell

Parent/Guardian #2 Name \_\_\_\_\_

Relationship: \_\_\_\_\_

Day Phone \_\_\_\_\_ Night Phone \_\_\_\_\_

Day Phone is  Home  Work  Cell Night Phone is  Home  Work  Cell

Additional Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_

(In case we can't reach YOU)

Day Phone \_\_\_\_\_ Night Phone \_\_\_\_\_

Day Phone is  Home  Work  Cell Night Phone is  Home  Work  Cell

Family Physician Name \_\_\_\_\_ Phone \_\_\_\_\_

Dentist/Orthodontist Name \_\_\_\_\_ Phone \_\_\_\_\_

## SECTION II – INSURANCE INFORMATION

Is the camper covered by family medical/hospital insurance?  Yes  No

If yes, indicate Insurance Carrier \_\_\_\_\_

Group # \_\_\_\_\_ Policy # \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Relationship to participant \_\_\_\_\_

### SECTION III – MEDICATIONS

Will camper be taking medications while at camp?  Yes  No (Medications include prescription, over-the-counter, vitamins, inhalers, etc.)

If camper will be taking medications while at camp, it is Wisconsin state law to secure your consent for medication distribution and for the use of medical devices. The medication can be self-administered (if over 18) or administered by Health Services Staff. Please list all (prescription and non-prescription). Include the medication name, prescribing physician, physicians' phone number, and the dosage instructions. Use an additional sheet if needed. When you check-in at camp, please provide all medications (in their original packaging that identifies the prescribing physician (if prescription drug), the name of the medication, the dosage, and frequency of administration.

\_\_\_\_\_ I want the medication or medical devices self-administered. (Age 18 and above only.)

\_\_\_\_\_ I want the medication or medical device administered by the Health Services Staff. However, a limited amount of medication for life threatening conditions should be carried by my son/daughter/ward. (i.e. bee sting kits, inhalers)

Medication \_\_\_\_\_ Dosage \_\_\_\_\_ Take at what times \_\_\_\_\_

Reason for Taking \_\_\_\_\_

Prescribing Physician \_\_\_\_\_ Phone \_\_\_\_\_

Medication \_\_\_\_\_ Dosage \_\_\_\_\_ Take at what times \_\_\_\_\_

Reason for Taking \_\_\_\_\_

Prescribing Physician \_\_\_\_\_ Phone \_\_\_\_\_

Medication \_\_\_\_\_ Dosage \_\_\_\_\_ Take at what times \_\_\_\_\_

Reason for Taking \_\_\_\_\_

Prescribing Physician \_\_\_\_\_ Phone \_\_\_\_\_

### SECTION IV – ALLERGIES

Camper does not have any Allergies

Camper is allergic to

1. Hay Fever  2. Poison Ivy/Oak  3. Insect Stings  4. Food  5. Penicillin  6. Other Drugs  7. Other

List allergy. Describe reaction and treatment

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### SECTION V – IMMUNIZATIONS

Please record the month and year of immunizations. If you do not know the dates or whether camper has had certain immunizations, simply leave blank.

DPT (Diphtheria, Pertussis, Tetanus)..... \_\_\_\_\_

Tetanus Booster ..... \_\_\_\_\_

Polio..... \_\_\_\_\_

MMR (Measles, Mumps, Rubella)..... \_\_\_\_\_

HIB (Haemophilus Influenza B)..... \_\_\_\_\_

Tuberculin Test ..... \_\_\_\_\_

Varicella (Chicken Pox)..... \_\_\_\_\_

Hepatitis B ..... \_\_\_\_\_

## SECTION VI – HEALTH HISTORY

*Please know that we value your privacy. Health History information is available only to the camp health staff. The more information you provide, the better we can do our job. Thanks!*

Has the camper have a history of or is prone to any of the following (Please check all that apply).

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> 1. Recent injury, illness or infectious disease | <input type="checkbox"/> 10. Hypertension                      | <input type="checkbox"/> 21. Fractures                |
| <input type="checkbox"/> 2. Chronic or recurring illness                 | <input type="checkbox"/> 11. Bleeding/Clotting Disorders       | <input type="checkbox"/> 22. Frequent Headaches       |
| <input type="checkbox"/> 3. Asthma                                       | <input type="checkbox"/> 12. Diabetes                          | <input type="checkbox"/> 23. Head Injury              |
| <input type="checkbox"/> 4. Homesickness                                 | <input type="checkbox"/> 13. Mononucleosis (in last 12 months) | <input type="checkbox"/> 24. Eating Disorder          |
| <input type="checkbox"/> 5. Frequent Ear Infections                      | <input type="checkbox"/> 14. Chicken Pox                       | <input type="checkbox"/> 25. Diarrhea or constipation |
| <input type="checkbox"/> 6. Seizure Disorder or Convulsions              | <input type="checkbox"/> 15. Measles                           | <input type="checkbox"/> 26 Frequent Stomachaches     |
| <input type="checkbox"/> 7. Dizziness during or after exercise           | <input type="checkbox"/> 16. German Measles                    | <input type="checkbox"/> 27 Wears glasses or contacts |
| <input type="checkbox"/> 8. Chest pain during or after exercise          | <input type="checkbox"/> 17. Mumps                             | <input type="checkbox"/> 28 Been Hospitalized         |
| <input type="checkbox"/> 9. Heart Defect/Disease                         | <input type="checkbox"/> 18. Tuberculosis                      | <input type="checkbox"/> 29 Wears a Medic Alert ID    |
|  | <input type="checkbox"/> 19. Hepatitis                         |   |
|  | <input type="checkbox"/> 20. Joint problems (knees, ankles)    |   |

Please list the number and provide explanation for any checked items

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Date of Last Physical Exam (Recommended within 24 months of camp) \_\_\_\_\_

Physical Activities to be Limited or Restricted while at Camp

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## SECTION VII – AUTHORIZATION

My child has permission to engage in all prescribed camp activities except as noted. The information provided on this form is accurate to the best of my knowledge. I have indicated any special health conditions, including required medication and activity limitations which should be known to the camp staff and medical personnel. I am aware of and accept the risk inherent in the program activity. I give consent in advance for medical treatment at an appropriate facility in case of illness or injury.

Signature of Parent or Guardian X \_\_\_\_\_ Date \_\_\_\_\_