

Wisconsin District Camp Health Screening

Section 1: Camper

Last Name: _____ First: _____ Middle: _____

Address: _____ Date of Birth _____

City, State, Zip: _____ Home Phone: _____

Home Church: _____ City: _____

Pastor: _____ Pastor's Phone: _____

Section 2: Parent or Guardian/Emergency Contact (if camper is under 18)

Last Name: _____ First: _____ Relationship: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____

Insurance Carrier: _____ Insurance Carrier Phone: _____

Policy #: _____

Section 3: Health History (to be filled out by parent or guardian) Y=yes N=no

Is camper subject to:

____ Frequent Colds	____ Sinus Trouble	____ Seizures	____ Allergies
____ Sleep Walking	____ Bed Wetting	____ Fainting	____ Asthma

Treatment for any above conditions: _____

Has camper had:

____ Rheumatic Fever ____ Scarlet Fever ____ Head Lice, if so last occurrence? _____

____ Chicken Pox ____ Appendicitis ____ Hernia ____ Mumps

____ Tuberculosis ____ Heat Exhaustion ____ Polio

____ Breathing/Lung Disorder explain: _____

____ Heart Trouble, if so, medication used: _____

____ Sugar Diabetes, if so, is insulin used? ____yes ____no Insulin Type: _____

Other Diabetes medication used: _____

Does camper have allergic reaction to:

____ Drugs, please list: _____

____ Animals, please list: _____

____ Food, please list: _____

____ Stings, please list: _____

List treatment for stings: _____

Does camper carry a bee sting kit? ____ yes ____ no Location of kit: _____

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Date of last Tetanus shot: **REQUIRED:** _____

Are immunizations current? ____ yes ____ no If no, please explain: _____

Is camper currently taking any medications? ____ yes ____ no If yes, please list medications, dosage and reason for taking. *Medications MUST be kept in the nurse's station if the camper is not with a parent: (exception: asthma inhaler):* _____

Any recent exposure to communicable diseases? ____ yes ____ no If yes, please explain:

Description of any physical condition requiring special attention: _____

Any specific activities to be restricted? (explain) _____

Does the camp nurse have permission to give camper: Aspirin ____ yes ____ no

Tylenol: ____ yes ____ no

Ibuprofen: ____ yes ____ no

Anti- histamine: ____ yes ____ no

Decongestant: ____ yes ____ no

Please list any other conditions/situations that camp staff should know about the camper:

Section 4: Medical Screening - By Certified Medical Personnel:

I have screened the above applicant and approve of his/her participation in the physical and out-of-doors activities of the camp program.

Please list any restrictions or concerns: _____

Signature: _____ Title: _____

Phone: _____ Date: _____

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