

# 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 in original pharmacy container & stored in the nurse's station if the camper is not with a parent: (exception: asthma inhaler):* \_\_\_\_\_

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

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Description of any physical condition requiring special attention: \_\_\_\_\_

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Any specific activities to be restricted? (explain) \_\_\_\_\_

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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:

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## 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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