

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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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 and MUST be in original pharmacy bottle with label intact: (exception: asthma inhaler):* (Please fill out a Meds-Allergies form if your child will be keeping medication with the nurse)_____

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: _____

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

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

This health history is correct so far as I know, and is up to date as of the last 90 days. The person herein describe d has permission to engage in all prescribed camp activities except as noted. Emergency Authorization: I hereby give permission to the medical personnel selected by the camp officials to order x-rays, routine tests and treatment for me or my child, as in the event I cannot be reached in an emergency. I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for me or my child as named above. I hereby give permission to transport me or my child for medical assistance. I hereby give permission to the WI District UPCI Camps to use photos, likenesses, and images of me for marketing and publicity purposes. This form may be photocopied for use at camp. I understand that I am responsible for payment of all medical treatments received from non-camp sources. I also give permission for the camp medical staff to administer over-the-counter medications to my child, that the physician has approved on page 2 of this form. I also give permission for my child to participate in all camp activities.

Parent/Legal Guardian Signature: REQUIRED: _____

Relationship to 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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Please list all medications taken by your child, including time and dosage.

Medications	A.M.	P.M.

Please indicate if your child has any allergies, and what they are.

Allergic to:

Notes: _____
