Wisconsin District Camp Health Screening

SECTION 1: PERSONAL INFORMATION

Last Name:_____ First:_____ Middle:_____

Address: _____ Date of Birth:_____

City, State, Zip:_____ Home Phone:_____

Home Church:_____ City:_____

Pastor:_____ Pastor's Phone:_____

Insurance Carrier: _____ Insurance Carrier Phone:_____

Policy number:_____

SECTION 2: EMERGENCY CONTACT

Last Name:_____First:_____ Relationship:_____

Address: _____ City, State, Zip:_____

Home Phone:_____ Work Phone:_____

SECTION 3: HEALTH HISTORY (Y=YES, N=NO) Are you subject to:

____ Frequent Colds ____ Sinus Trouble ____ Seizures ____ Allergies

____ Sleep Walking ____ Bed Wetting ____ Fainting ____ Asthma

Treatment for any above conditions:

Have you 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:

Name: _____

SECTION 3: HEALTH HISTORY (CONT.)

Are you 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 page 3 of this screening if your child will be keeping medication with the nurse) _____

_____

Any recent exposure to communicable diseases? ____YES ____NO If yes, please explain:

_____

_____

DescripWorktion of any physical condition requiring special attention:

_____

_____

Any specific activities to be restricted? (explain)

_____

_____

Does the camp nurse have permission to give you:

Tylenol: ____ YES ____ NO Ibuprofen: ____ YES ____ NO Aspirin ____ 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 described 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. 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 I have approved on page 2 of this form. I also give permission for my child to participate in all camp activities.

Signature (*REQUIRED***):** _____

SECTION 4: MEDICAL SCREENING – By Certified Medical Personnel (*REQUIRED***):**

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:_____