

CAMP HEALTH & MEDICATION FORM
 FOR YOUTH AND ADULTS
 WAUKESHA COUNTY

For office use only:

This side to be filled in by parents/guardians of minors.

Last Name _____ First _____ MI _____ Birth Date _____ Age _____ Sex _____
 Primary Parent/Guardian _____ Home Phone(____) _____
 Address _____ Work Phone(____) _____
 City _____ State _____ Zip Code _____ Cell Phone(____) _____
 Secondary Parent/Guardian _____ Home Phone(____) _____
 Address _____ Work Phone(____) _____
 City _____ State _____ Zip Code _____ Cell Phone(____) _____
 If not available in an emergency, notify: Name _____ Phone(____) _____

Health History: (give approximate dates)

Frequent ear infections _____	Mononucleosis _____	<u>Allergies</u>
Heart Defect/Disease _____		Hay Fever _____
Convulsions _____	<u>Diseases:</u>	Poison Ivy _____
Diabetes _____	Chicken Pox _____	Insect Stings _____
Bleeding/Clotting Disorders _____	Measles _____	Penicillin _____
Hypertension _____	German Measles _____	Other Drugs _____
	Mumps _____	Asthma _____

Any known medical reactions ___NO ___ YES, explanation: _____

Are eyeglasses required? _____ Contacts? _____

Recent operations or serious injuries (include dates): _____

Disability or chronic or recurring illness: _____

Any specific activities to be encouraged or limited by physician's advice: _____

Dietary Modifications: _____

Name of Dentist/Orthodontist: _____ Phone(____) _____

Name of Family Physician: _____ Phone(____) _____

Date of last physical examination: _____

Medical Insurance Carrier: _____ Group Number _____

Policy Number _____ Other Number _____

Suggestions _____ or _____ health _____ related _____ information _____ for _____ camp
 personnel: _____

(For females) Any special considerations related to menstruation? _____

This health history is correct so far as I know, and the person listed above has permission to engage in all prescribed camp activities except as noted. I hereby give permission to the camp to: 1. Provide ongoing health care. 2. To select medical personnel and to order x-rays or routine tests or treatment for the person listed above.

EMERGENCY AUTHORIZATION: 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 the person named above. This form may be photocopied for use out of camp.

Parent/Guardian of minor or adult staffer: _____ Date _____

I also understand and agree to abide with the restrictions placed on my camp activities:

Signature of minor: _____ Date _____

(OVER)

MEDICATIONS FORM

CAMPER'S NAME: _____

IF THE CAMPER NEEDS "OVER THE COUNTER" MEDICATION FOR HEADACHE OR COLDS DO WE HAVE PERMISSION TO ADMINISTER ___ YES ___ NO
(IF YES - PLEASE NOTE SUGGESTED MEDICATIONS AND DOSAGE: _____)

DOES CAMPER CARRY AN INHALER WITH THEM? ___ YES ___ NO (IF YES, WHAT TYPE?) _____

SHOULD CAMPER CARRY ANY OTHER MEDICATION WITH THEM? ___ YES ___ NO (IF YES, WHAT TYPE?) _____

IF CAMPER NEEDS TYLENOL DO WE HAVE PERMISSION TO ADMINISTER? ___ YES ___ NO
IF YES PLEASE NOTE SUGGEST DOSAGE _____

IF CAMPER NEEDS IBUPROFEN DO WE HAVE PERMISSION TO ADMINISTER? ___ YES ___ NO
IF YES PLEASE NOTE SUGGEST DOSAGE _____

MEDICATION CAMPER IS TO HAVE AT CAMP! ALL MEDICINE MUST BE HELD BY THE CAMP HEALTH PERSON AND WILL BE DISPENSED PER THE INSTRUCTIONS BELOW. BE SURE THAT THE MEDICINE IS IN THE ORIGINAL CONTAINERS.

NAME OF MEDICATION DOSAGE IS THIS MEDICATION OPTIONAL? _____	SCHEDULE OF MEDICATION OR REQUIRED? _____
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NAME OF MEDICATION DOSAGE IS THIS MEDICATION OPTIONAL? _____	SCHEDULE OF MEDICATION OR REQUIRED? _____
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* IF YOU NEED MORE PLACES FOR MEDICATIONS, MAKE A COPY OF THIS FORM.

ANY OTHER CONCERNS: _____