CAMPER HEALTH AND MEDICAL HISTORY

This side to be filled out by parent, legal guardian, or camper over age 18.
Please read carefully.

The Salvation Army
Wonderland Camp & Conference Center
9241 Camp Lake Rd., P.O. Box 222
Camp Lake, WI 53109
Tel. (262) 889-4305
Fax (262) 889-4307

Camper Name ______________________ Birth date __________ Age _____ Sex _____
LAST FIRST INITIAL

Parent / Legal Guardian / Spouse ______________________

Home Address ______________________ Phone __________
STREET & NUMBER CITY STATE ZIP (AREA CODE) – NUMBER

Business Address ______________________ Phone __________
STREET & NUMBER CITY STATE ZIP (AREA CODE) – NUMBER

Second Parent / Legal Guardian / Emergency Contact ______________________

Home Address ______________________ Phone __________
(Address different than above) STREET & NUMBER CITY STATE ZIP (AREA CODE) – NUMBER

Business Address ______________________ Phone __________
(Address different than above) STREET & NUMBER CITY STATE ZIP (AREA CODE) – NUMBER

If not available in an emergency, notify: ______________________
FIRSTNAME LASTNAME

Home address ______________________ Phone __________
(Address different than above) STREET & NUMBER CITY STATE ZIP (AREA CODE) – NUMBER

HEALTH HISTORY
(Check and give approximate dates.)

_____ Frequent Ear Infections
_____ Heart Defect/Disease
_____ Convulsions/Seizures
_____ Diabetes
_____ Bleeding/Clotting Disorders
_____ High Blood Pressure
_____ Mononucleosis
_____ Psychiatric Treatment
_____ Strep Throat
_____ Lead Poisoning
_____ Sickle Cell

Diseases

_____ Chicken Pox
_____ Measles
_____ German Measles
_____ Mumps

Allergies/Allergic Conditions

_____ Hay Fever
_____ Ivy Poisoning, etc.
_____ Insect Stings (reaction?) __________
____

_____ Penicillin
_____ Other Drugs
_____ Asthma (reaction?) __________
____

_____ Other (Specify) __________
____

Has camper ever required hospitalization, medical, or other treatment? _____ Yes _____ No Explain:
____

Operations or serious injuries (dates) ______________________

Disability or chronic or recurring illness ______________________

Other diseases/conditions ______________________

Dietary Restrictions ______________________

Special restrictions or considerations regarding health related information while at camp: __________
____

Name of dentist/orthodontist __________ Phone __________

Name of family physician/clinic ______________________

Phone __________ **Fax** __________

Do you carry family medical/hospital insurance _____ Yes _____ No

If so, indicate: Carrier ______________________

Policy or Group # ______________________

Medical Assistance # ______________________

For Females (under age 18)
Has this person menstruated? __________ If not has she been told about it? __________

If so, is her menstrual history normal? __________ Special considerations? __________

This box must be signed & dated prior to camp attendance

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted.
Authorization for treatment: I hereby give permission for the camp medical personnel to give myself/my child First Aid and medication as described in the camp standing orders, to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for myself/my child. In the event I (parent or guardian) or my emergency contacts cannot be reached in a n emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for myself/my child (camper under age 18) named above. The completed forms may be photocopied for transport out of camp.

X ______________________ X __________
SIGNATURE OF PARENT / LEGAL GUARDIAN / ADULT CAMPER OVER AGE 18 DATE

I also understand and agree that the person documented above will abide with the restrictions placed on his/her camp activities.

HF – 1 Revised 3/2003 The sole purpose of this information is to identify appropriate health care needs.

(Camp will Complete)
Name:
Cabin:
Date:
Notes:
Session #:

HEALTH HISTORY INFORMATION FOR: CAMPER NAME: ______________________ DATE: __________

IMMUNIZATION HISTORY

Required immunizations must be determined locally. Please record the date (month and year) of basic immunizations and most recent booster doses.

VACCINES	YEAR OF BASIC IMMUNIZATION	YEAR OF LAST BOOSTER
DPT (Diphtheria, Pertussis, Tetanus)	1 2 3 1	2
Or		
TD (Tetanus, Diphtheria)	1 2 3 1	2
Polio		
MMR (measles, mumps, rubella)		
Tuberculin test given / / (most recent)		
Hepatitis B 1	**2 3**	

MEDICATION POLICY

If your child is bringing medication to camp, please read the following policy carefully:

1. Your child must continue all medications (i.e. prescription or over the counter), as ordered by the licensed prescribing physician, while at camp.
2. Each medication sent with the camper must be accompanied by a separate Medication Administration Form completed by the prescribing physician. The form, located below (which may be photocopied if needed for more than one prescription), is required by Wisconsin State Law.
3. In order for your child to attend camp, the medication must be present and a completed Medication Administration Form must be on file at camp.
4. Each medication must be in its original container; having the name of the person to whom it was prescribed clearly marked on the label.
5. The medication label must also contain the prescribing physician's name, prescription date, expiration date and name of the prescription clearly marked on it.
6. All medication will be given according to the label directions unless otherwise specified in writing by the prescribing physician.
7. All medication will be kept in, and given out from, the Health Center by the camp nurse—except inhalers, which may be kept with the camper or counselor at the nurse's discretion.
8. **DO NOT** send non-prescription, over-the-counter drugs, creams, lotions, or other treatments with your child—unless prescribed by the licensed physician. We supply these items based on the Camp's standing orders.

No Physician Signature Is Required Unless You Are Bringing Medication To Camp

MEDICATION ADMINISTRATION FORM (Camper Name):______________________

Any camper (under 18 years of age) who needs medication dispensed at camp MUST have this form filled out and signed by the prescribing physician before any medication can be administered. **Use only one form for each prescription and have it completed by each prescribing physician**. The information is required by Wisconsin State Law HSS 175.14 (6) (a.,b.)*. **PHOTOCOPY AS NEEDED**.

Name of medication ______________________ Dosage ______________ Frequency ______________

Duration ______________________ Route ______________ Adverse Reactions ______________

Specific conditions when a physician should be contacted/other instructions ______________________

Prescribing Physician's Name ______________________ **Phone ( )** ______________

Signed and Stamped by Physician Date

Fax ( ) ______________

*HSS 175.14 (6) (a., b.) Medications. All medications brought to camp by a camper or staff member under 18 years of age shall be in containers which identify the medications and the camper or staff member, shall be kept in a locked unit and shall be administered by the camp health supervisor as prescribed by a licensed physician with a record of treatment maintained. Each staff member 18 years or older shall be responsible for the security of his or her personal life-threatening medication or as approved by the camp's health care provider in accordance with the camp's health care procedures. 0303