



Wisconsin Department of Agriculture, Trade and Consumer Protection
 Division of Food and Recreational Safety
 Phone: (608) 224-4720

CAMPER HEALTH HISTORY RECORD!

Wis. Admin. Code ch. ATCP 78

PLEASE PRINT

CAMPER'S PERSONAL INFORMATION (please print)

CAMPER'S NAME (Last, First, Middle Initial) , ,	BIRTHDATE (Mo/Day/Yr.) / /	SEX	TELEPHONE NUMBER (Home) () -	
MAILING ADDRESS STREET	CITY		STATE	ZIP
NAME OF PARENT/GUARDIAN/LEGAL CUSTODIAN	WORK TELEPHONE NUMBER () -		CELL PHONE NUMBER () -	
NAME OF PARENT/GUARDIAN/LEGAL CUSTODIAN	WORK TELEPHONE NUMBER () -		CELL PHONE NUMBER () -	

CAMPER'S HEALTH CARE PROVIDER INFORMATION

HEALTH CARE PROVIDER NAME				
MEDICAL FACILITY NAME				TELEPHONE NUMBER () -
MEDICAL FACILITY STREET ADDRESS		CITY	STATE	ZIP

ALLERGIES

☐ This camper has no known allergies

<input type="checkbox"/> THIS CAMPER IS ALLERGIC TO THIS FOOD(S):	DOES THIS ALLERGY CAUSE ANAPHYLAXIS? <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE OF MOST RECENT EPISODE?	FREQUENCY OF EPISODE?	DESCRIBE REACTION AND HOW IT IS MANAGED?
<input type="checkbox"/> THIS CAMPER IS ALLERGIC TO THIS MEDICATION(S):	DOES THIS ALLERGY CAUSE ANAPHYLAXIS? <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE OF MOST RECENT EPISODE?	FREQUENCY OF EPISODE?	DESCRIBE REACTION AND HOW IT IS MANAGED?
<input type="checkbox"/> THIS CAMPER IS ALLERGIC TO THE FOLLOWING:	DOES THIS ALLERGY CAUSE ANAPHYLAXIS? <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE OF MOST RECENT EPISODE?	FREQUENCY OF EPISODE?	DESCRIBE REACTION AND HOW IT IS MANAGED?

MEDICATION

☐ This camper **will NOT** take any medications while attending camp.

☐ This camper **will** take the following medication(s) while attending camp. I am bringing enough medication to last the entire session and it is in the original container labeled by the pharmacy.

Medication or Treatment	Dose	When do you give it at home?	Reason for taking medication

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PLEASE CONTINUE ON REVERSE SIDE

ASTHMA

<input type="checkbox"/> This camper does NOT have asthma.		<input type="checkbox"/> This camper does have asthma.	
Asthma Triggers (check all that apply)		Signs/Symptoms of asthma episode	Frequency of episodes
<input type="checkbox"/> Exercise	<input type="checkbox"/> Colds		
<input type="checkbox"/> Infections	<input type="checkbox"/> Emotions		
<input type="checkbox"/> Allergies (to what?)			
<input type="checkbox"/> Weather (what type?)			
<input type="checkbox"/> Other (list)			
How episode is managed			

IMMUNIZATIONS

List the MONTH, DAY, AND YEAR your child received each of the following immunizations. DO NOT USE (√) OR (X) except to answer the question about chickenpox, Tdap or Td. If you do not have an immunization record for this child at home, contact your doctor or public health department to obtain it. A copy of the child's complete immunization record from the WIR may be attached to this form (www.dhfswir.org).

TYPE OF VACCINE*	FIRST DOSE Mo/Day/Yr	SECOND DOSE Mo/Day/Yr	THIRD DOSE Mo/Day/Yr	FOURTH DOSE Mo/Day/Yr	FIFTH DOSE Mo/Day/Yr
DTaP/DTP/DT/Td (Diphtheria, Tetanus, Pertussis)					
Adolescent booster (Check appropriate box) <input type="checkbox"/> Tdap* <input type="checkbox"/> Td					
Polio					
Hepatitis B					
MMR (Measles, Mumps, Rubella)					
Meningococcal Conjugate Vaccine (MCV)*					
Hepatitis A					
Varicella (Chickenpox) Vaccine – Vaccine is needed only if your child has not had Chickenpox disease. See below:					
Has your child had Varicella (chickenpox) disease? Please check appropriate box and provide the date (if known): <input type="checkbox"/> YES (please list month/year): ____/____ <input type="checkbox"/> NO or Unsure (Vaccine recommended)					
Influenza (date of most recent dose): ____/____					

*These vaccines are routinely recommended at age 11-12 years.

- ☐ For health reasons, this child is not fully immunized.
☐ For personal conviction or religious reasons, this child is not fully immunized.

LIST VACCINE(S) NOT RECEIVED:

OTHER MEDICAL CONDITIONS

PLEASE INDICATE ANY OTHER IMPORTANT MEDICAL CONDITIONS (eg. diabetes, seizures, physical conditions, etc.)

SIGNATURE

The information included on this form is complete and accurate to the best of my knowledge.

SIGNATURE – Parent/Guardian/Legal Custodian

DATE

Please return this completed form directly to your Rec Ed Camp.

Personal information you provide may be used for purposes other than that for which it was originally collected. Wis. Stat. § 15.04(1)(m)

CONSENT TO MEDICAL TREATMENT

NAME OF CAMPER: _____ BIRTH DATE: _____

NAME OF PARENT/GUARDIAN: _____ E-MAIL: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

HOME ADDRESS: _____
Street City State Zip

Please read and complete the following:

Camp director(s) and/or camp medical staff will administer all medication. All prescription medication **MUST** be in its **ORIGINAL** bottle. This should be labeled with the camper's name, doctor's name, medication name, dosage, prescription number, date prescribed, and instructions. Please check what applies below:

- ☐ No medication(s) will be brought to camp.
- ☐ I want the medication to be self-administered (age 18 and above only).
- ☐ I want the medication administered by camp staff; however, a limited amount of medication for life-threatening conditions may be carried by my son/daughter (i.e. inhaler, insulin syringe, etc.)
- ☐ I allow camp staff to administer proper dosage of Tylenol and Ibuprofen as needed and administered by the camp nurse for headaches, minor bumps, or bruises.

I AGREE TO THE FOLLOWING:

- I am giving my consent in advance for medical treatment at an appropriate medical facility in case of illness or injury.
- I am stating that I am aware of, and accept the risk inherent in program activity. ▪ I

attest that all information I have provided on all forms is correct.

- I agree to hold harmless and indemnify Camp and Immanuel Lutheran College, their officers, facilities, agents, volunteers, and employees from any and all liability, loss, damages, costs, expenses which are sustained, incurred, or required arising out of the actions of my son, daughter, or ward in the course the camp.

SIGNATURE OF PARENT OR LEGAL GUARDIAN DATE