All Camps (GSDC) - Camper Health History **2018**

IMPORTANT: This is a two-sided document, please be sure to complete BOTH pages/sides.

Each camper must have a completed and current health history form on file which has been completed by the parents or guardian of the camper.

Camper Name _____ M ☐ F ☐ ____/____/____
First Middle Last Birth date

Parent/Guardian Name _____
First Middle Last

Home Address _____
Street City State Zip

Parent/Guardian Phone Home (____) _____ Work (____) _____ Cell (____) _____

Emergency Contacts: List 2 people (friend or relative), we may notify in case of an emergency if we cannot reach you:

1. Name _____ Relationship to Camper _____

Home (____) _____ Work (____) _____ Cell (____) _____

2. Name _____ Relationship to Camper _____

Home (____) _____ Work (____) _____ Cell (____) _____

Doctor's Name _____ **Doctor's Phone#:** _____

Insurance Information

Is the person described in this health history covered by health insurance? ☐ Yes ☐ No If yes, provide the following information:

Insurance Company Name _____ Insurance ID Number _____

Plan Name _____ Group Number _____

Name of Insured _____ Relationship to camper _____

I attest that all immunizations required for this camper for school are up to date ☐ Yes ☐ No

Date of Last Tetanus Shot **(required information):** Month and Year _____

Medical History – Has the camper or adult staff member ever had or currently have: (check all that apply)

Measles	☐ YES	☐ NO	Mononucleosis	☐ YES	☐ NO	Hepatitis A	☐ YES	☐ NO
Chicken Pox	☐ YES	☐ NO	Learning Disability	☐ YES	☐ NO	Hepatitis B	☐ YES	☐ NO
German Measles	☐ YES	☐ NO	ADD or ADHD	☐ YES	☐ NO	Hepatitis C	☐ YES	☐ NO
Mumps	☐ YES	☐ NO	Heart Murmur	☐ YES	☐ NO	Difficulty Hearing	☐ YES	☐ NO
Diabetes	☐ YES	☐ NO	Asthma	☐ YES	☐ NO	Vision Problems	☐ YES	☐ NO
Frequent Headaches	☐ YES	☐ NO	Frequent Ear Infections	☐ YES	☐ NO	Bed Wetting	☐ YES	☐ NO
Dizziness	☐ YES	☐ NO	Fainting Spells	☐ YES	☐ NO	Rheumatic Fever	☐ YES	☐ NO
Seizures	☐ YES	☐ NO	Chest Pain	☐ YES	☐ NO	Hay Fever	☐ YES	☐ NO
Menstrual Abnormalities	☐ YES	☐ NO	High Blood Pressure	☐ YES	☐ NO	Poison Ivy	☐ YES	☐ NO
Acne or rashes	☐ YES	☐ NO	Diarrhea/Constipation	☐ YES	☐ NO	Insect Stings	☐ YES	☐ NO
Back Pain	☐ YES	☐ NO	Joint Pain	☐ YES	☐ NO	Serious Injury	☐ YES	☐ NO
Frequent Nightmares	☐ YES	☐ NO	Sleepwalking	☐ YES	☐ NO	Operations	☐ YES	☐ NO

Give details for any items marked "yes" above (indicate treatment or specifics.)

_____

Please provide any additional information concerning this camper's current physical, mental or psychological conditions requiring medication, treatment or special restrictions or considerations while at camp.

_____

-Over-

Should there be any restriction on this person's activity while at camp due to health reasons?
☐ **YES** ☐ **NO**

If yes, please explain (what can or cannot be done and what adjustments or limits are needed): _____

_____

_____

Does this camper presently take any over the counter or prescribed medications? ☐ **YES** ☐ **NO**

If yes, please list all over the counter or prescribed medications below. (If more than 4 medications are taken, please attach a list on a separate sheet of paper.) The medication form will also need to be completed.

Medication # 1 _____ Medication #2 _____

Medication # 3 _____ Medication # 4 _____

List All Allergies (Medicine, Food, Insect Stings, Hay Fever, Animals, etc.)

Allergy	Reaction	Treatment

PLEASE NOTE:

Meal substitutions can be made but require a written recommendation and signature from a health care professional. Please have this information included on the health exam form which is signed by a doctor.

Does this person have any dietary restrictions or religious preference? ☐ **Yes** ☐ **No**

☐ **Gluten Free** ☐ No Red Meat ☐ No Pork ☐ No Poultry ☐ No Eggs

Please describe : _____

Parent/Guardian Authorization

- The person described in this health history has permission to engage in all camp activities except as noted.
- I give permission to camp staff to provide routine healthcare at camp including administering first aid and medications.
- I authorize camp staff to obtain medical treatment for the person described in this health history.
- I give permission to the physician selected by the Camp Director to order x-rays or routine tests and to secure treatment for, to order injection and/or anesthesia and/or surgery for the person described in this health history.
- I give permission for the camp staff to arrange necessary transportation to obtain medical treatment for the person described in this health history.
- I agree to the release of medical records necessary for insurance purposes.
- Photocopies of this form may be used for off camp trips.

_____ _____

Signature of parent/guardian **Date**

Return to: COA Youth & Family Centers 909 E. Garfield Avenue Milwaukee, WI 53212
Phone: (414) 290-7903 Fax: (414) 264-2336