



# Youth Health Form

Camp Site (addresses on p.4)

Camp Name and Date

**Directions: Please complete this form and mail it to the appropriate camp two weeks before camp starts. ALL Sections are REQUIRED.** The following information must be filled in by the Parent/Guardian. Please provide complete information so that the camp can be aware of your child's needs and provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. **\*\*An additional medical exam will be required for all boundary water trip campers.\*\***

*\*If you registered online, you may complete this form there also. If you haven't registered online, but would like to complete the health form online, please contact the camp office for assistance at 608-837-3388 between 8 a.m. and 4 p.m. Monday thru Friday.\**

## I. CAMPER & CONTACT INFORMATION

Camper Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Gender \_\_\_\_ Age \_\_\_\_  
Last First Middle

Home Address \_\_\_\_\_  
Street & Number City State ZIP

First Parent/Guardian \_\_\_\_\_ Email \_\_\_\_\_  
 Phone: Home (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

Second Parent/Guardian \_\_\_\_\_ Email \_\_\_\_\_  
 Phone: Home (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

If not available in an emergency, notify:

Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ Alternate Phone (\_\_\_\_) \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ Alternate Phone (\_\_\_\_) \_\_\_\_\_ Relationship: \_\_\_\_\_

## II. CARE PROVIDERS

Name of family physician \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
 Name of dentist/orthodontist \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
 Medical/hospital insurance carrier \_\_\_\_\_ I have no medical/hospital insurance \_\_\_\_

**Please attach copy of insurance card (both sides).**

## III. MEDICAL CONSENT AGREEMENT

**Participant's Name:** \_\_\_\_\_

### **CERTIFICATION AND CONSENT TO AUTHORIZE MEDICAL CARE FOR MINOR.**

By signing below I, the undersigned, am stating that I have legal custody of the Camper whose name is set forth above. I, the undersigned, hereby grant my authorization and consent to The Wisconsin Annual Conference of The United Methodist Church and The Wisconsin Conference Board of Trustees of The United Methodist Church, Inc., and their employees, clinicians, trainers, nurses, or agents, to administer first aid treatment for any minor injuries or illnesses and, if the injury is life threatening or in need of emergency treatment, to seek, approve, and obtain any medical, dental or surgical diagnosis, treatment or care for the Camper including, but not limited to, x-ray, anesthetic, injections, medications, blood transfusions, and hospitalization, which is deemed advisable by, and is to be rendered under the general supervision of a physician, surgeon, dentist, hospital or other medical professional or institution. I authorize the release of any and all medical records concerning the Camper to any health care provider authorized to provide care or treatment pursuant to this Medical Consent Agreement. I, the undersigned, agree to assume financial responsibility for all expenses of such care. I, the undersigned, have read, and I understand, all of the provisions of this Agreement.

\_\_\_\_\_  
Parent or Guardian's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Participant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian's Name (Printed)

\_\_\_\_\_  
Participant's Date of Birth

IV. HEALTH HISTORY:

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Date of Last Medical Exam: \_\_\_\_\_

Has your child experienced, or is currently experiencing, any of the following conditions?

- |   | Yes/No  |  | Yes/No  |
|---|---|--|---|
| 1. Recent injury, illness or infectious disease? .....  | <input type="checkbox"/> <input type="checkbox"/> | 17. Back problems?.....  | <input type="checkbox"/> <input type="checkbox"/> |
| 2. Chronic or recurring illness/condition?.....         | <input type="checkbox"/> <input type="checkbox"/> | 18. Joint problems? .....  | <input type="checkbox"/> <input type="checkbox"/> |
| 3. Ever been hospitalized? .....                        | <input type="checkbox"/> <input type="checkbox"/> | 19. Wears a removable orthodontic appliance? .....                                   | <input type="checkbox"/> <input type="checkbox"/> |
| 4. Ever had any operations?.....                        | <input type="checkbox"/> <input type="checkbox"/> | 20. Skin problems? .....   | <input type="checkbox"/> <input type="checkbox"/> |
| 5. Frequent headaches? .....                            | <input type="checkbox"/> <input type="checkbox"/> | 21. Diabetes? .....  | <input type="checkbox"/> <input type="checkbox"/> |
| 6. A head injury?.....                                  | <input type="checkbox"/> <input type="checkbox"/> | 22. Asthma/Inhaler? .....  | <input type="checkbox"/> <input type="checkbox"/> |
| 7. Knocked unconscious?.....                            | <input type="checkbox"/> <input type="checkbox"/> | 23. Mononucleosis in the past 12 months? .....                                       | <input type="checkbox"/> <input type="checkbox"/> |
| 8. Wear glasses, contacts, or protective eye wear? .... | <input type="checkbox"/> <input type="checkbox"/> | 24. Problems with diarrhea/constipation? .....                                       | <input type="checkbox"/> <input type="checkbox"/> |
| 9. Frequent ear infections? .....                       | <input type="checkbox"/> <input type="checkbox"/> | 25. Sleepwalking? .....  | <input type="checkbox"/> <input type="checkbox"/> |
| 10. Passed out during or after exercise? .....          | <input type="checkbox"/> <input type="checkbox"/> | 26. If female, abnormal menstrual history?.....                                      | <input type="checkbox"/> <input type="checkbox"/> |
| 11. Been dizzy during or after exercise? .....          | <input type="checkbox"/> <input type="checkbox"/> | 27. History of bed-wetting?.....   | <input type="checkbox"/> <input type="checkbox"/> |
| 12. Had seizures? .....                                 | <input type="checkbox"/> <input type="checkbox"/> | 28. Ever had an eating disorder?.....  | <input type="checkbox"/> <input type="checkbox"/> |
| 13. Had chest pain during or after exercise? .....      | <input type="checkbox"/> <input type="checkbox"/> | 29. ADD/ADHD?.....   | <input type="checkbox"/> <input type="checkbox"/> |
| 14. Had high blood pressure?.....                       | <input type="checkbox"/> <input type="checkbox"/> | 30. Speech challenges? .....   | <input type="checkbox"/> <input type="checkbox"/> |
| 15. Bleeding/clotting disorder? .....                   | <input type="checkbox"/> <input type="checkbox"/> | 31. Ever had emotional difficulties for which<br>professional help was sought? ..... | <input type="checkbox"/> <input type="checkbox"/> |
| 16. Diagnosed with a heart murmur?.....                 | <input type="checkbox"/> <input type="checkbox"/> |  |   |

Please explain "yes" answer(s) from above, noting the number of the question(s).

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Please share any other information about the participant's behavior and physical, emotional, or mental health that may be helpful to our staff in meeting the needs of your youth.

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V. RESTRICTIONS

The following **dietary** restrictions apply to this individual:

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Explain any **activity** restrictions (e.g., what cannot be done, what adaptations or limitations are necessary).

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## VI. IMMUNIZATION HISTORY

\* To protect the health of those who are medically unable to receive immunizations, we encourage campers to be vaccinated prior to the start of camp.

Please give all dates of immunizations: you may attach a record from your doctor or the state health department.

	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
Tetanus	_____	_____	_____	_____	_____	_____
DTP	_____	_____	_____	_____	_____	_____
TD (Tetanus/diphtheria)	_____	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____	_____
MMR	_____	_____	_____	_____	_____	_____
or Measles	_____	_____	_____	_____	_____	_____
or Mumps	_____	_____	_____	_____	_____	_____
or Rubella	_____	_____	_____	_____	_____	_____
Haemophilus InfLuenza B ( <i>Hib B</i> )	_____	_____	_____	_____	_____	_____
Hepatitis B	_____	_____	_____	_____	_____	_____
Varicella (Chicken pox)	_____	_____	_____	_____	_____	_____

If your child has not been fully immunized, please explain: \_\_\_\_\_

Which of the following diseases has the participant had?

- |                                      |   |                                      |   |
|--------------------------------------|---|--------------------------------------|---|
| <input type="checkbox"/> Measles     | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Mumps          |
| <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Hepatitis B    | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> German Measles |

## VII. ALLERGIES

Please list all known Allergies. Describe reaction and management of the reaction.

Medication:

_____	_____
_____	_____
_____	_____

Food:

_____	_____
_____	_____
_____	_____

Insect stings/Bees:

_____	_____
_____	_____
_____	_____

Other:

_____	_____
_____	_____
_____	_____
_____	_____

### VIII. MEDICATION AUTHORIZATION

Camper Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Camp name \_\_\_\_\_

**I approve the administration of the following over-the-counter medications by the camp health staff as needed:**

- Ibuprofen and/or  Acetaminophen (Tylenol) for headache, minor discomfort or fever
- Hydrocortisone cream and/or  Benadryl for itching/discomfort caused by irritants and/or allergies.
- Insect Repellent
- Sunscreen

**I am sending the following Prescription and/or over-the-counter Medications with my child:**

**Please keep all medications (prescription or over-the-counter) in original containers.**

**ALL** medications should be listed on this form and clearly labeled with:

- 1) Camper name; 2) Name of medication; 3) Dosage; 4) Frequency of administration; 5) Method of administration;
- and*

If the medication has been prescribed by a physician, the label *must* also include:

- 6) Name of prescribing physician; 7) Prescription number; 8) Date prescribed; 9) Possible adverse reactions; 10) Specific conditions when contact should be made with physician; 11) Other special instructions:

**Name of Medication** \_\_\_\_\_ **Date Prescribed:** \_\_\_\_\_

**Dosage:** \_\_\_\_\_ **Frequency:** \_\_\_\_\_ **Method of Administration:** \_\_\_\_\_

**Possible Side Effects:** \_\_\_\_\_

**Special Instructions:** \_\_\_\_\_

**Why has this medication been prescribed?** \_\_\_\_\_

**Contact the Physician When:** \_\_\_\_\_

**Name of Medication** \_\_\_\_\_ **Date Prescribed:** \_\_\_\_\_

**Dosage:** \_\_\_\_\_ **Frequency:** \_\_\_\_\_ **Method of Administration:** \_\_\_\_\_

**Possible Side Effects:** \_\_\_\_\_

**Special Instructions:** \_\_\_\_\_

**Why has this medication been prescribed?** \_\_\_\_\_

**Contact the Physician When:** \_\_\_\_\_

**Name of Medication** \_\_\_\_\_ **Date Prescribed:** \_\_\_\_\_

**Dosage:** \_\_\_\_\_ **Frequency:** \_\_\_\_\_ **Method of Administration:** \_\_\_\_\_

**Possible Side Effects:** \_\_\_\_\_

**Special Instructions:** \_\_\_\_\_

**Why has this medication been prescribed?** \_\_\_\_\_

**Contact the Physician When:** \_\_\_\_\_

\*\*\* Please add additional pages as needed.

### IX. PICK-UP AUTHORIZATION

\_\_\_\_\_ is authorized to pick up \_\_\_\_\_ at the conclusion of camp.  
(Name of person authorized to pick up camper) (Camper Name)

\_\_\_\_\_  
(Signature of Parent/Guardian) (Date)

Camp Addresses:

Lake Lucerne Camp  
W6460 County Road YY  
Neshkoro, WI 54960

Pine Lake Camp  
W8301 County Road M  
Westfield, WI 53964