



Wisconsin Department of Agriculture, Trade and Consumer Protection

Division of Food and Recreational Safety

P.O. Box 8911, Madison, WI 53708-8911

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CAMPER HEALTH HISTORY RECORD

Wis Admin. Code § ATCP 78.27(1)(d)

Use of this form is recommended to meet camper health history record keeping requirements under *Wis. Admin. Code ch. ATCP 78*. Personally identifiable information may be used for purposes other than for which it is originally being collected. *Wis. Stat. § 15.04(1)(m)*. Failure to keep accurate camper health history records is subject to compliance action under *Wis. Admin. Code ch. ATCP 78*.

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

PLEASE PRINT

CAMPER'S PERSONAL INFORMATION *(please print)*

FIRST NAME:	MIDDLE INIT.:	LAST NAME:	BIRTHDATE (Mo/Day/Yr.): / /	SEX:	PRIMARY PHONE NUMBER: () -
MAILING ADDRESS STREET:			CITY:	STATE:	ZIP:
NAME OF PRIMARY PARENT/LEGAL CUSTODIAN IN CASE OF ILLNESS OR INJURY:			WORK TELEPHONE NUMBER: () -	CELL PHONE NUMBER: () -	
NAME OF SECOND PARENT/LEGAL CUSTODIAN IN CASE OF ILLNESS OR INJURY:			WORK TELEPHONE NUMBER: () -	CELL PHONE NUMBER: () -	

CAMPER'S HEALTH CARE PROVIDER INFORMATION

HEALTH CARE PROVIDER NAME:	
MEDICAL FACILITY NAME:	TELEPHONE NUMBER: () -
<input type="checkbox"/> This camper has no known allergies.	
<input type="checkbox"/> This camper is allergic to this food(s):	<input type="checkbox"/> Does this allergy cause anaphylaxis? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> This camper is lactose intolerant.	<input type="checkbox"/> This camper is gluten intolerant.
<input type="checkbox"/> Other <i>(please explain)</i> :	
<input type="checkbox"/> This camper is allergic to medication(s):	<input type="checkbox"/> Environment (insect stings, hay fever, etc) <input type="checkbox"/> Other:
Please describe below what this camper is allergic to and the reaction seen:	

MEDICATION

<input type="checkbox"/> This camper will NOT take any medications while attending camp (over the counter or prescribed).					
<input type="checkbox"/> 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.					
Name of Medication	Amount or Dose Given	Reason for Taking It	When It Is Given	How It Is Given	Emergency Medication Only Legal Guardian to initial below if camper is able to carry and self-administer (i.e. inhaler, epi- pen)
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time:		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time:		

			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time:		
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MEDICAL INSURANCE INFORMATION:

The camper is covered by family medical/hospital insurance. Yes No

Insurance Company:	Policy Number:
Subscriber:	Insurance Company Phone Number: () -

ASTHMA

This camper **does NOT** have asthma. This camper **does** have asthma.

Asthma Triggers (check all that apply)		Signs/Symptoms of asthma episode	Frequency of episodes	How episode is managed
<input type="checkbox"/> Exercise	<input type="checkbox"/> Colds			
<input type="checkbox"/> Infections	<input type="checkbox"/> Emotions			

Allergies (to what?)

Weather (what type?)

Other (list)

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 <http://www.dhfs.wisconsin.gov> or from healthcare providers, state, or local government are also acceptable.

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 (IPV)					
Hepatitis B					
MMR (Measles, Mumps, Rubella)					
Varicella (Chickenpox) Vaccine Vaccine is needed only if your child has not had Chickenpox disease.			Has your child had Varicella (chickenpox) disease? <input type="checkbox"/> Yes, year: <input type="checkbox"/> No or Unsure (vaccine needed)		

For health reasons, this child is not fully immunized.

For personal conviction or religious reasons, this child is not fully immunized. **Include any immunizations received above.*

RESTRICTIONS:

I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.

I have reviewed the program activities of the camp and feel the camper can participate with the following restrictions or adaptations
(Please describe below):

OTHER CAMPER CONSIDERATIONS

PLEASE INDICATE ANY OTHER IMPORTANT MEDICAL CONDITIONS
(eg. Diabetes; seizures; physical conditions; non-prescription medications not to be given; mental, emotional, or social health)

SIGNATURE

This health history is correct and accurately reflects the health status of the camper. The person described has permission to participate in all camp activities except as noted by me or an examining physician. I give permission to the camp to provide routine healthcare services, administer medications, and seek emergency services.

SIGNATURE – Parent/Guardian/Legal Custodian

DATE

Health Refusal Form

I, _____, refuse to fill out the health history form for myself and/or my child, I understand that refusal to fill out the health history form is in violation of the Kenosha WI, Health Code. In the event of personal health emergency, I will not hold Carthage College liable for any accident that may occur during my stay at Carthage.

Minor or Participant's Name

Participant or Legal Guardian's Signature