

# 2010 Adult health form

Session # \_\_\_\_\_ Dates \_\_\_\_\_ Last name \_\_\_\_\_

Wisconsin administrative code HFS 175.14 (2) requires that each adult must provide an up-to-date health history.

**Please return this form at least 4 weeks prior to arrival at camp.**

Send to: Camp Phillip W9944 Buttercup Ave Wautoma, WI 54982 or fax to: (920) 787-0032.

## Participant's information

Name \_\_\_\_\_  
Date of birth \_\_\_\_\_ Age \_\_\_\_ Sex:  Male  Female  
Home address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ Zip+4 \_\_\_\_\_  
Home phone + area code \_\_\_\_\_  
Cell phone + area code \_\_\_\_\_  
Work phone + area code \_\_\_\_\_

## Emergency contact

Name \_\_\_\_\_  
Relationship to camper \_\_\_\_\_  
Home phone + area code \_\_\_\_\_  
Cell phone + area code \_\_\_\_\_  
Work phone + area code \_\_\_\_\_

## Dentist

Name \_\_\_\_\_  
City \_\_\_\_\_  
Phone + area code \_\_\_\_\_

## Family physician

Name \_\_\_\_\_  
City \_\_\_\_\_  
Phone + area code \_\_\_\_\_

## Health history

Check all that apply and explain:

- ADD or behavioral disorders \_\_\_\_\_
- Asthma \_\_\_\_\_  
If so, do you have an inhaler?  Yes  No
- Bed wetting \_\_\_\_\_
- Bleeding/clotting disorders \_\_\_\_\_
- Convulsions \_\_\_\_\_
- Diabetes \_\_\_\_\_  
If so, do you monitor blood sugar?  Yes  No  
If so, what is the frequency? \_\_\_\_\_
- Epilepsy \_\_\_\_\_
- Frequent ear infections \_\_\_\_\_
- Heart defect / disease / problems \_\_\_\_\_
- Hypertension \_\_\_\_\_
- Psychiatric treatment \_\_\_\_\_
- Skin disorder \_\_\_\_\_
- Sleep walking \_\_\_\_\_
- Stomach problems \_\_\_\_\_

Check all that apply and give approximate month and year:

- Chicken pox \_\_\_\_\_
- German measles \_\_\_\_\_
- Measles \_\_\_\_\_
- Mononucleosis \_\_\_\_\_
- Mumps \_\_\_\_\_

Date of last tetanus shot \_\_\_\_\_

Check which of the following can be given if necessary:

- Antacid  Benadryl  Cough drops/syrup
- Decongestant  Ibuprofen  Tylenol

Please list all allergies (including food, drug & environmental)

Is camper allergic to bee stings?  Yes  No

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please share any other health information or physical conditions that may need special consideration (attach additional pages if necessary):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Insurance information

Should there be any medical expenses resulting from an accident at camp, Camp Phillip's insurance policy requires us to file with the participant's insurance first; any part of the bill not covered by the participant's insurance can then be filed with the camp's insurance company. Bills from an illness requiring medical attention are the responsibility of the participant.

Do you carry medical, health or hospital insurance?  Yes  No

Carrier \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip+4 \_\_\_\_\_

Phone \_\_\_\_\_ Policy or group # \_\_\_\_\_ Participant's social security # \_\_\_\_\_

→ Please turn to the back side.

## Medications

Wisconsin administrative code HFS 175.14 (6) requires that "all medications brought to camp shall be in containers that are clearly labeled to include the name of the camper, the name of the medication, the dosage, the frequency of administration and the route of administration. All medication prescribed by a physician shall, in addition, be labeled to include the name of the prescribing physician, the prescription number, date prescribed, possible adverse reactions, the specific conditions when contact should be made with the physician and other special instructions as needed."

If this information is not provided on the medication, please use the chart below (or additional paper) to supply that information.

Name of medication			
Dosage			
Frequency			
Route			
Possible adverse reactions			
Specific conditions when contact should be made with the physician			
Other special instructions			

## Consent for emergency treatment, assumption of responsibilities and risk and release of liability

- ✓ With or without a doctor's advice, I give my permission to engage in all camp activities except those listed herein.
- ✓ I take responsibility for informing health care staff of any changes in my health condition upon arrival at camp and give them permission to administer routine medications.
- ✓ In the event I cannot give consent during an emergency, I hereby give permission for any medical treatment or hospitalization as needed. I also agree to be liable for any and all costs involved in such treatment.
- ✓ While camp staff strive to reduce risks to participants, accidents can and do occur. I understand that there is inherent risk involved in camp activities which is beyond Camp Phillip's control. [We must inform you that potential accidents in camp programs may include, but may not be limited to: blisters, insect stings, sunburn, sprains, cuts, bruises, dislocations, fractures, concussion, spinal cord damage or even death.] I agree to personally assume such risks.
- ✓ I release Camp Phillip, and other sponsoring agencies, their employees and volunteers from all liability for any damage, injury or loss which may be sustained en route, during or returning from camp.
- ✓ My signature below affirms my understanding and agreement with the above statements.

**Participant's signature** \_\_\_\_\_ **Date signed** \_\_\_\_\_

## Physical exam (optional)

If you choose to provide us with this information, it must be completed by a qualified physician, registered nurse or other person recognized by law to undertake that responsibility. Use this form unless another recently completed form is available.

Date of exam \_\_\_\_\_ Person performing exam \_\_\_\_\_ Title \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip+4 \_\_\_\_\_ Phone + area code \_\_\_\_\_

- 1) In my opinion, the applicant's condition (check one)  would  would not allow for participation in an active camp program.
- 2) The applicant is under the care of a physician for the following condition/s:
- 3) List any current treatments and medications currently being taken:
- 4) List any treatments to be continued at camp:
- 5) Explain below any recent loss of consciousness, convulsions or concussions:
- 6) Does applicant have any seizure disorders?  Yes  No      Does applicant have diabetes?  Yes  No
- 7) List any medically prescribed meal plan or dietary restrictions:
- 8) Allergies (food, drugs, environmental, insects . . .)
- 9) Additional health information:

**Examiner's signature** \_\_\_\_\_