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 by 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 _____