

## CAMP HEALTH EXAMINATION FORM

Session: \_\_\_\_\_ Dates \_\_\_\_\_

This side to be filled out by parent/guardian or adult camper, and reviewed with physician at time of examination.

### Camper's Personal Information:

First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Boy  Girl  Birthday \_\_\_\_/\_\_\_\_/\_\_\_\_ Age on first day of session \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_

### Guardian Information:

Mother/Guardian First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

E-Mail \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Ex. \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Father/Guardian First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

E-Mail \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Ex. \_\_\_\_\_

City, State, Zip \_\_\_\_\_

### Emergency Contacts: (To be contacted if parent/guardian is not available in an emergency)

Name	Relationship	Daytime Phone	Night Phone
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Name	Relationship	Daytime Phone	Night Phone
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### Health History: (Give dates)

Medication Allergies (list)

Describe Reaction and management of the reaction.

_____	_____
_____	_____

Food Allergies (list)

Describe Reaction and management of the reaction.

_____	_____
_____	_____

Other Allergies (list)

Describe Reaction and management of the reaction.

_____	_____
_____	_____

Provide any information regarding the participant's behavior (i.e. – physical, emotional or mental health) about which the camp should be aware:

_____
_____

**Which of the following has the participant had?**

<input type="checkbox"/> Measles	Year _____	<input type="checkbox"/> Chicken Pox	Year _____	<input type="checkbox"/> German Measles	Year _____
	Year _____		Year _____		Year _____
<input type="checkbox"/> Mumps	Year _____	<input type="checkbox"/> Hepatitis A	Year _____	<input type="checkbox"/> Hepatitis B	Year _____
	Year _____		Year _____		Year _____
<input type="checkbox"/> Hepatitis C	Year _____	<input type="checkbox"/> Pertussis	Year _____		

**Other health concerns? (list most recent date of occurrence)**

<input type="checkbox"/> Ear Infection	Date _____	<input type="checkbox"/> Rheumatic Fever	Date _____	<input type="checkbox"/> Convulsions	Date _____
	Date _____		Date _____		Date _____
<input type="checkbox"/> Diabetes	Date _____	<input type="checkbox"/> Asthma	Date _____		

Medications currently being taken \_\_\_\_\_

Any specific activities to be restricted \_\_\_\_\_

Operations or Serious Injuries (dates) \_\_\_\_\_

Chronic or Recurring Illness \_\_\_\_\_

**(For Girls and Women)**

Has this person menstruated? \_\_\_\_\_ If not, has she been told about it? \_\_\_\_\_ If so, is menstrual history normal? \_\_\_\_\_

Special considerations: \_\_\_\_\_

**Immunization History:** (Please give all dates of immunization)

Vaccine	Date:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Date:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP		_____	_____	_____	_____	MMR	_____	_____	_____	_____
Tetanus/diphtheria		_____	_____	_____	_____	Or Measles	_____	_____	_____	_____
Tetanus		_____	_____	_____	_____	Or Mumps	_____	_____	_____	_____
Polio		_____	_____	_____	_____	Or Rubella	_____	_____	_____	_____
Haemophilus Influenza B		_____	_____	_____	_____	Hepatitis B	_____	_____	_____	_____
Varicella (chicken pox)		_____	_____	_____	_____					

**Health Insurance Carrier Information**

*Must include a photocopy of both sides of insurance card.*

Insurance Carrier \_\_\_\_\_ Group and/or Policy Number \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Policy Holder's Birthday \_\_\_/\_\_\_/\_\_\_

**Parent/Guardian's Release and Authorization for Treatment**

This health history is correct and complete as far as I know. The person herein named has permission to engage in all camp activities except as noted.  
Authorization for Treatment:

I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, administration of over the counter medicine and emergency treatment for me/my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

It is my intention that the camp be treated as acting in loco parentis if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the purpose of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR 164.510 (b)) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: (i) in the case of minors, to provide relevant information to the camp representatives related to the person's ability to participate in camp activities; and (ii) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child's health status. I understand Camp Lakotah does not cover camper health and medical expenses. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

# Camp Lakotah

N1875 21<sup>st</sup> Ave.  
Wautoma, WI 54982

## Medical Examination Form

To be completed by licensed M.D., R.N., or Equivalent. This examination should be performed within 24 months of arrival at camp. Each camper must have a physical examination on file in order to attend camp.

Date of Exam: \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ B.P. \_\_\_\_\_

In my opinion, the above applicant:  is able to participate in active camp program activities with no restrictions.

is able to participate in an active camp program with the restrictions indicated below.

Applicant is under the care of a physician for the following conditions: \_\_\_\_\_

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

### Recommendations and Restrictions at Camp

Treatment to be continued at camp \_\_\_\_\_

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

Medications to be administered at camp (name, dosage, frequency) \_\_\_\_\_

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

Known allergies \_\_\_\_\_

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

Description of any limitation on camp activities \_\_\_\_\_

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

Additional information for health care staff at the camp \_\_\_\_\_

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

Signature of Licensed Medical Personnel \_\_\_\_\_

Printed \_\_\_\_\_ Title \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Date \_\_\_\_\_