



Summer Staff Heath Form

_____ Camp Site

Directions: Complete sections A, B, C, D, E, F, G, I, J yearly. Complete Section H within 24 months of arrival at camp. Mail Health Form to Lake Lucerne Camp, W6460 County Rd YY, Neshkoro, WI 54960.

A.	Camper Name _____ Birth Date _____ Sex _____ Age _____ <small style="display: block; text-align: center;">Last First Middle</small>
Camper & Parent Information	Parent or Guardian _____ Phone (_____) _____
	Home Address _____ <small style="display: block; text-align: center;">Street & Number City State ZIP</small>
	Cell Phone _____ Cell Phone _____ Email _____
	Business Address _____ Business Phone (_____) _____ <small style="display: block; text-align: center;">Street & Number City State ZIP</small>
	Business Address _____ Business Phone (_____) _____ <small style="display: block; text-align: center;">Street & Number City State ZIP</small>
	If not available in an emergency, notify: Name _____ Phone (_____) _____ Business Phone (_____) _____

B.	Name of dentist/orthodontist _____ Phone (_____) _____
Care Providers	Name of family physician _____ Phone (_____) _____ <small>(If other than examining physician)</small>
	Medical/hospital insurance carrier _____
	Address: _____ Phone (_____) _____
	Policy # _____ Group # _____ I have no medical/hospital insurance.
Please attach copy of insurance card (both sides).	

C.	MEDICAL CONSENT AGREEMENT	
Medical Consent	Participant's Name: _____	
	<p><u>CERTIFICATION AND CONSENT TO AUTHORIZE MEDICAL CARE FOR MINOR.</u> As the parent or legal guardian of the Participant whose name is set forth above, I hereby delegate 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, the authority to seek, obtain, and approve any medical care and treatment for the Participant including, but not limited to, x-ray examination, anesthetic, injection, medical, dental or surgical diagnosis, or treatment and medical care, which is deemed advisable by, and is to be rendered under the general supervision of any physician or surgeon, during, or as the result of, Participant's participation in the Activities. I authorize the release of any and all medical records concerning the Participant to any health care provider authorized to provide care or treatment pursuant to this Medical Consent Agreement. I authorize payment be rendered directly to hospital or doctor for benefits otherwise payable to me by any third party. I have read, and I understand, all of the provisions of this Agreement.</p>	
	Parent or Guardian's Signature _____ Date _____	Participant's Signature _____ Date _____
	Parent or Guardian's Name (Printed) _____	Participant's Date of Birth _____

COMPLETE THE ENTIRE FORM
Please attach copy of insurance card (both sides).

Please complete this form and mail it to the appropriate camp two weeks before the start date of your camp. If unable to mail the form, please bring it to camp. **DO NOT** mail form to Camping Office.

D.

Allergies

The following information must be filled in by the parent/guardian. The intent of this information is to provide camp health care personnel the background to 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. Provide complete information so that the camp can be aware of your needs.

ALLERGIES List all known. Describe reaction and management of the reaction.

Medication allergies (list)

Food allergies (list)

Other allergies (list)

E.

General Questions

General Questions: (Explain "yes" answers below.)

Has/does the participant:

- | | Yes/No | | Yes/No |
|--|--------|--|--------|
| 1. Have any recent injury, illness or infectious disease? .. | Y / N | 16. Ever been diagnosed with a heart murmur? .. | Y / N |
| 2. Have a chronic or recurring illness/condition? | Y / N | 17. Ever had back problems? | Y / N |
| 3. Ever been hospitalized? | Y / N | 18. Ever had problems with joints? | Y / N |
| 4. Ever had surgery? | Y / N | 19. Wear a removable orthodontic appliance? ... | Y / N |
| 5. Have frequent headaches? | Y / N | 20. Have any skin problems? | Y / N |
| 6. Ever have a head injury? | Y / N | 21. Have diabetes? | Y / N |
| 7. Ever been knocked unconscious? | Y / N | 22. Have asthma? | Y / N |
| 8. Wear glasses, contacts, or protective eye wear? | Y / N | 23. Had mononucleosis in the past 12 months? .. | Y / N |
| 9. Ever had frequent ear infections? | Y / N | 24. Had problems with diarrhea/constipation? ... | Y / N |
| 10. Ever passed out during or after exercise? | Y / N | 25. Have problems with sleepwalking? | Y / N |
| 11. Ever been dizzy during or after exercise? | Y / N | 26. If female, abnormal menstrual history? | Y / N |
| 12. Ever had seizures?..... | Y / N | 27. Have a history of bed-wetting? | Y / N |
| 13. Ever had chest pain during or after exercise? | Y / N | 28. Ever had an eating disorder? | Y / N |
| 14. Ever had high blood pressure? | Y / N | 29. Ever had emotional difficulties for which | |
| 15. Ever had bleeding/clotting disorder? | Y / N | professional help was sought? | Y / N |

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

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware.

F.
Restrictions

RESTRICTIONS
The following restrictions apply to this individual:

Dietary, circle all that apply

Does not eat red meat	Does not eat pork	Does not eat eggs
Does not eat poultry	Does not eat seafood	Does not eat dairy products

Other (describe) _____

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

G.
Immunization History

Which of the following has the participant had?		Please give all dates of immunizations:					
		Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
Measles		Tetanus	_____	_____	_____	_____	_____
German measles	DTP		_____	_____	_____	_____	_____
Chicken pox		TD (tetanus/diphtheria)	_____	_____	_____	_____	_____
Mumps	Polio		_____	_____	_____	_____	_____
Hepatitis A		MMR	_____	_____	_____	_____	_____
Hepatitis B		or Measles	_____	_____	_____	_____	_____
Hepatitis C		or Mumps	_____	_____	_____	_____	_____
		or Rubella	_____	_____	_____	_____	_____
TB Mantoux test	Haemophilus Infuenza B	_____	_____	_____	_____	_____	_____
Date of last test _____		Hepatitis B	_____	_____	_____	_____	_____
Result: Positive Negative		Varicella (Chicken pox)	_____	_____	_____	_____	_____

H.
Medical Examination

To be filled out by a licensed Physician, Physician Assistant, or Registered Nurse. **This examination should be performed within 24 months of arrival at camp.** Examination for some other purpose within this period is acceptable. (Attach form.) Examination is for determining fitness to engage in strenuous activities.

Please mark "S" for Satisfactory and explain any unsatisfactory items. (Attach page)

Height _____ Weight _____ B.P. _____

Eyes _____ Throat _____ Abdomen _____ General Appraisal: _____

Glasses/Contacts _____ Heart _____ Hernia _____ Ears _____ Skin _____

Extremities _____ Nose _____ Lungs _____ Posture (Spine) _____

Allergy (Please specify) _____

Recommendations and restrictions while in camp: Special Diet (See Section F) _____

Current Medications _____

Swimming _____ Strenuous activity _____

Other _____

(For Girls and Women) Has this person menstruated? _____ If not, has she been told about it? _____

If so, is her menstrual history normal? _____ Special considerations: _____

I have examined the person herein described and have reviewed the health history. It is my opinion that this camper is physically able to engage in camp activities, except as noted above.

Physician, Physician Assistant, or Registered Nurse

Date

Telephone (____) _____ Address _____

I. PICK-UP AUTHORIZATION

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

(Signature of Parent/Guardian) (Date)

J. MEDICATION AUTHORIZATION

Any prescription or over-the-counter medications brought to camp need to be in original containers and listed on this form.

Camper Name: _____ Birth Date: _____ Camp #: _____

Name of Medication _____ Date Prescribed: _____

Dosage: _____ Frequency: _____

Method of Administration: _____ Duration: _____

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: _____ Duration: _____

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: _____ Duration: _____

Possible Side Effects: _____

Special Instructions: _____

Why has this medication been prescribed? _____

Contact the Physician When: _____

Please label **ALL** medications clearly including the following information and keep in original containers:

- 1) Camper or staff member 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:

TO BE FILLED IN BY CAMP HEALTH SUPERVISOR

List routine treatment required during camp period, for example, further examination, special food, injections, or prescriptions:

Record of illness or accidents:		
DATE	COMMENT	TREATMENT

Conditions arising in camp which should be called to the attention of the parents or guardians:

Record medical reimbursement claims: _____

Signature of Camp Health Supervisor _____ Date _____

(For insurance purposes, this record should be kept on file in the camp site office.)