



# UNITED METHODIST CAMPS WISCONSIN CONFERENCE CAMP HEALTH FORM

\_\_\_\_\_ *Camp Number/Name*

**Mail to camp site 2 weeks prior to camp start date**

\_\_\_\_\_ *Camp Site*

Please complete one form per camper  
Complete Sections A, B, C, D, E, F, G, I, J **yearly**. **Complete Section H within 24 months** of arrival at camp

<b>A.</b>  <b>Camper &amp; Parent Information</b>	Camper Name _____ Birth Date _____ Sex _____ Age _____ Last First Middle
	Parent or Guardian _____ Phone (_____) _____
	Home Address _____ Street & Number City State ZIP
	Cell Phone _____ Cell Phone _____ Email _____
	Business Address _____ Business Phone (_____) _____ Street & Number City State ZIP
	Business Address _____ Business Phone (_____) _____ Street & Number City State ZIP
	If not available in an emergency, notify: Name _____ Phone (_____) _____ Business Phone (_____) _____

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

**Please attach copy of insurance card (both sides).**

<b>C.</b>  <b>Medical Consent</b>	<b>MEDICAL CONSENT AGREEMENT</b>	
	Participant's Name: _____	
	<b>CERTIFICATION AND CONSENT TO AUTHORIZE MEDICAL CARE FOR MINOR.</b> 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.	
	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
<input type="checkbox"/> Measles	Tetanus	_____	_____	_____	_____	_____
<input type="checkbox"/> German measles	DTP	_____	_____	_____	_____	_____
<input type="checkbox"/> Chicken pox	TD (tetanus/diphtheria)	_____	_____	_____	_____	_____
<input type="checkbox"/> Mumps	Polio	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis A	MMR	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis B	or Measles	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis C	or Mumps	_____	_____	_____	_____	_____
	or Rubella	_____	_____	_____	_____	_____
<input type="checkbox"/> TB Mantoux test	Haemophilus Infuenza B	_____	_____	_____	_____	_____
Date of last test _____	Hepatitis B	_____	_____	_____	_____	_____
Result: <input type="checkbox"/> Positive <input type="checkbox"/> 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.)