

SPECIAL NEEDS CAMP HEALTH FORM

Complete one form per camper by parent, guardian, or staff

Camp #: _____

Camp Site: _____

A.	<p>Camper Name _____ Birth Date _____ Sex _____ Age _____ Last First M.I.</p> <p>Camper Address _____ Street & Number City State ZIP</p> <p>Camper Phone (_____) _____ Camper residence is: <input type="checkbox"/> Independent <input type="checkbox"/> Parent(s) Home <input type="checkbox"/> Group Home <input type="checkbox"/> Other _____</p> <p>Names of significant people, pets, or places in this camper's life _____</p> <p>Does camper have a Legal Guardian or Power of Attorney for Healthcare? (If camper is a minor, answer YES) _____ If so, please provide the following:</p> <p>Name _____ Address _____ City _____ State _____ ZIP _____</p> <p>Daytime Phone (_____) _____ Evening Phone (_____) _____ Relationship _____</p> <p>Alternate Emergency Contact:</p> <p>Name _____ Address _____ City _____ State _____ ZIP _____</p> <p>Daytime Phone (_____) _____ Evening Phone (_____) _____ Relationship _____</p>
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B.	<p>Care Providers</p> <p>Name of dentist/orthodontist _____ Phone (_____) _____</p> <p>Name of primary physician _____ Phone (_____) _____</p> <p>Name of specialist(s)/ their specialty _____ Phone (_____) _____ _____ Phone (_____) _____</p> <p>Insurance carrier _____ Policy or Group No. _____</p> <p>Insurance carrier address _____ Phone (_____) _____</p>
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C.	<p>Participant's Name: _____</p> <p>Medical Consent</p> <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> <p>_____ Parent or Guardian's Signature Date Participant's Signature Date</p> <p>_____ Parent or Guardian's Name (Printed) Participant's Date of Birth</p>
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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.

Restrictions

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

Yes/No

Yes/No

Has/does the participant:

- | | | | |
|--|-------|--|-------|
| 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.

E.

General Questions

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).



F. Health Examination Record

To Be Completed by a Licensed Physician, Physician's Assistant, or Registered Nurse. This examination should be performed within 12 months of arrival at camp.

Wisconsin United Methodist Special Needs Camps

Please Print

Name _____ (Last) _____ (First) _____ (Middle)

Date of Birth _____ General Appearance _____

Health History: (Check all that apply)

Asthma _____	Allergies-Reactions (Describe)
Bleeding/clotting disorders _____	Latex _____
Diabetes _____	Bee stings _____
Frequent ear infections _____	Environmental _____
Heart defects/disease _____	Medications _____
Seizures (type/frequency) _____	Foods _____
Fainting _____	Other _____
Please describe all that are checked: _____	Other _____

Surgeries or serious injuries (dates) _____

Any specific activities to be encouraged? _____
 restricted? _____

Diagnoses of any current, chronic, or recurring conditions (i.e., frequent colds, sore throat, stomach upset, constipation, diabetes, heart abnormalities, etc.) _____

Current treatments or therapies other than oral medications (including topical ointments, physical therapy, counseling, specific approaches to common problems specific to this camper, etc.) _____

Classification For Physical Activity

- _____ Regular
- _____ Restricted (eliminate strenuous activity)
- _____ Corrective (individual exercises)
- _____ Suggestions _____
- _____ Complete Rest (restricted to sitting/walking)
- _____ One-to-one Supervision for all bathing and water activities

Diseases - Immunizations/Dates

Chicken pox _____
Measles _____
Mumps _____
German measles/3 day _____
Rubella _____
Hepatitis _____
Tetanus _____
_____ A B C

Age: _____ Height: _____ Weight: _____

S = Satisfactory **NS** = Not Satisfactory **O** = Not

Skin _____	Thyroid Gland _____	Bones/Muscles _____	Abdomen _____
Scalp _____	Lymph Glands _____	Spine _____	Scars _____
Eyes _____	Breasts - Chests _____	Upper Extremities _____	Abnormalities _____
Ears _____	Deformity _____	Lower Extremities _____	Hernia _____
	Lungs _____	Feet _____	
Naso-Pharynx _____	Urine _____	Posture _____	Genitalia _____
Abnormalities _____	Albumin _____	Cardiovascular _____	Abnormalities _____
Tonsils _____	Specific Gravity _____	Blood Pressure _____	Neurological _____
Mouth _____	Sugar _____	Pulse _____	Reflexes _____
Teeth _____	Microscopic _____	Heart Abnormalities _____	Tremor _____
Gums _____			Ties, etc. _____
			Other _____

Physician's Report Regarding Significant Findings of Health Examination:

Signature/Examining Physician: _____

Date _____

Phone: (_____) _____

G. PICK-UP AUTHORIZATION

_____ is authorized to pick-up _____
(Name of person authorized to pick-up camper) (Camper Name)

at the conclusion of camp.

Signature of Parent/Guardian Date

H. 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
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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.)

