Youth Health Form

_____
Camp Site *(addresses on p.4)*
Please don't mail to Sun Prairie after June 1.

_____
Camp Name and Date

Our preference is for you to complete your health form online at *www.wiumcamps.org/registration* If you are unable to, please complete this form and mail it to the appropriate camp two weeks before camp starts.
ALL Sections are REQUIRED. Information must be filled in by the Parent/Guardian. Please provide complete information so that the camp can be aware of your child's needs and 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.

If you registered online, you may complete this form there also. If you haven't registered online, but would like to complete the health form online, please contact the camp office for assistance at 608-296-2720 between 9 a.m. and 3 p.m. Monday thru Friday.

I. CAMPER & CONTACT INFORMATION

Camper Name _____ Birth Date _____ Gender ____ Age ____
(Last / First / Middle)

Home Address _____
(Street & Number / City / State / ZIP)

First Parent/Guardian _____ Email _____

Phone: Home (____)_____ Cell (___)_____ Work (____) _____

Second Parent/Guardian _____ Email _____

Phone: Home (____)_____ Cell (___)_____ Work (____) _____

If not available in an emergency, notify:

Name _____ Phone (____)_____ Alternate Phone (____)_____ Relationship: _____

Name _____ Phone (____)_____ Alternate Phone (____)_____ Relationship: _____

II. CARE PROVIDERS

Name of family physician _____ Phone (____) _____

Name of dentist/orthodontist _____ Phone (____) _____

Medical/hospital insurance carrier _____ I have no medical/hospital insurance ___

Please attach copy of insurance card (both sides).

III. MEDICAL CONSENT AGREEMENT

Participant's Name:_____

CERTIFICATION AND CONSENT TO AUTHORIZE MEDICAL CARE FOR MINOR.

By signing below I, the undersigned, am stating that I have legal custody of the Camper whose name is set forth above. I, the undersigned, hereby grant my authorization and consent 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, to administer first aid treatment for any minor injuries or illnesses and, if the injury is life threatening or in need of emergency treatment, to seek, approve, and obtain any medical, dental or surgical diagnosis, treatment or care for the Camper including, but not limited to, x-ray, anesthetic, injections, medications, blood transfusions, and hospitalization, which is deemed advisable by, and is to be rendered under the general supervision of a
physician, surgeon, dentist, hospital or other medical professional or institution. I authorize the release of any and all
medical records concerning the Camper to any health care provider authorized to provide care or treatment pursuant to this Medical Consent Agreement. I, the undersigned, agree to assume financial responsibility for all expenses of such care. I, the undersigned, 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

IV. HEALTH HISTORY:

Height:_____ Weight: _____Date of Last Medical Exam: _____

	Yes/No			Yes/No	
1. Recent injury, illness or infectious disease?	☐	☐	17. Back problems?	☐	☐
2. Chronic or recurring illness/condition?	☐	☐	18. Joint problems?	☐	☐
3. Ever been hospitalized?	☐	☐	19. Wears a removable orthodontic appliance?	☐	☐
4. Ever had any operations?	☐	☐	20. Skin problems?	☐	☐
5. Frequent headaches?	☐	☐	21. Diabetes?	☐	☐
6. A head injury?	☐	☐	22. Asthma/Inhaler?	☐	☐
7. Knocked unconscious?	☐	☐	23. Mononucleosis in the past 12 months?	☐	☐
8. Wear glasses, contacts, or protective eye wear?	☐	☐	24. Problems with diarrhea/constipation?	☐	☐
9. Frequent ear infections?	☐	☐	25. Sleepwalking?	☐	☐
10. Passed out during or after exercise?	☐	☐	26. If female, abnormal menstrual history?	☐	☐
11. Been dizzy during or after exercise?	☐	☐	27. History of bed-wetting?	☐	☐
12. Had seizures?	☐	☐	28. Ever had an eating disorder?	☐	☐
13. Had chest pain during or after exercise?	☐	☐	29. ADD/ADHD?	☐	☐
14. Had high blood pressure?	☐	☐	30. Speech challenges?	☐	☐
15. Bleeding/clotting disorder?	☐	☐	31. Ever had emotional difficulties for which professional help was sought?	☐	☐
16. Diagnosed with a heart murmur?	☐	☐			

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

_____

_____

_____

_____

_____

_____

_____

_____

Please share any other information about the participant's behavior and physical, emotional, or mental health that may be helpful to our staff in meeting the needs or your youth.

_____

_____

_____

V. RESTRICTIONS

The following **dietary** restrictions apply to this individual:

_____

_____

_____

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

_____

_____

_____

VI. IMMUNIZATION HISTORY

** To protect the health of those who are medically unable to receive immunizations, we encourage campers to be vaccinated prior to the start of camp.*

Please give all dates of immunizations: *you may attach a record from your doctor or the state health department.*

	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
Tetanus	_____	_____	_____	_____	_____	_____
DTP	_____	_____	_____	_____	_____	_____
TD (Tetanus/diphtheria)	_____	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____	_____
MMR	_____	_____	_____	_____	_____	_____
or Measles	_____	_____	_____	_____	_____	_____
or Mumps	_____	_____	_____	_____	_____	_____
or Rubella	_____	_____	_____	_____	_____	_____
Haemophilus InfLuenza B *(HIb B)*	_____	_____	_____	_____	_____	_____
Hepatitis B	_____	_____	_____	_____	_____	_____
Varicella (Chicken pox)	_____	_____	_____	_____	_____	_____

If your child has not been fully immunized, please explain: _____

Which of the following diseases has the participant had?

☐ Measles	☐ Whooping Cough	☐ Chicken Pox	☐ Mumps
☐ Hepatitis A	☐ Hepatitis B	☐ Hepatitis C	☐ German Measles

VII. ALLERGIES

Please list all known Allergies. Describe reaction and management of the reaction.

Medication:

_____ _____
_____ _____
_____ _____

Food:

_____ _____
_____ _____
_____ _____

Insect stings/Bees:

_____ _____
_____ _____
_____ _____

Other:

_____ _____
_____ _____
_____ _____
_____ _____

VIII. MEDICATION AUTHORIZATION

Camper Name: _____ Birth Date:_____ Camp name _____

I approve the administration of the following over-the-counter medications by the camp health staff as needed:

- ❑ Ibuprofen and/or ❑ Acetaminophen (Tylenol) for headache, minor discomfort or fever
- ❑ Hydrocortisone cream and/or ❑ Benadryl for itching/discomfort caused by irritants and/or allergies.
- ❑ Insect Repellent
- ❑ Sunscreen

I am sending the following Prescription and/or over-the-counter Medications with my child:

Please keep all medications (prescription or over-the-counter) in original containers. Pharmacy made pill packs are acceptable.
ALL medications should be listed on this form and clearly labeled with:
1) Camper 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:

Name of Medication _____ Date Prescribed:_____

Dosage:_____ Frequency:_____ Method of Administration:_____

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:_____

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:_____

Possible Side Effects:_____

Special Instructions:_____

Why has this medication been prescribed?_____

Contact the Physician When:_____

*** Please add additional pages as needed.

IX. PICK-UP AUTHORIZATION

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

_____ _____
(Signature of Parent/Guardian) (Date)

Camp Addresses:

Lake Lucerne Camp
W6460 County Road YY
Neshkoro, WI 54960

Pine Lake Camp
W8301 County Road M
Westfield, WI 53964