CAMP & RETREAT MINISTRIES
WISCONSIN CONFERENCE | UNITED METHODIST CHURCH

OASIS
DIFFERING ABILITY CAMP
HEALTH FORM

Camp Dates: _____

Mail to: PINE LAKE CAMP
W8301 Cty Rd M
Westfield WI 53964

Please complete this form and mail to Pine Lake Camp no later than two weeks before the start date of camp. All sections are required. Please provide complete information so that the camp can be aware of your camper'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.

A. Camper & Contact Information

Camper Name _____ Birth Date _____ Sex_____ Age_____
First M.I. Last

Camper Address_____
Street & Number City State ZIP

Camper Phone (____)_____ Camper residence is: Independent Parent(s) Home Family/Group Home Other _____

Names of significant people, pets, or places in this camper's life _____

Who is the camper's Legal Guardian or Power of Attorney for Healthcare?

Name_____Address_____City_____State_____ZIP_____

Daytime Phone (___)_____ Evening Phone (__)_____ Relationship_____

Alternate Emergency Contact: Name_____

Daytime Phone (___)_____ Evening Phone (__)_____ Relationship_____

B. Care Providers

Name of primary physician _____ Phone (____)_____

Name of dentist/orthodontist _____ Phone (____)_____

Insurance carrier _____

Please attach copy of insurance card (both sides).

C. Medical Consent

Participant's Name:_____

CERTIFICATION AND CONSENT TO AUTHORIZE MEDICAL CARE.
By signing below I, the undersigned, am stating that I have legal custody of the Participant 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 Participant 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 Participant 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

D. Health History:

Has the participant experienced, or is currently experiencing, any of the following conditions?

	Yes	No		Yes	No
1. Recent injury, illness or infectious disease?	☐	☐	11. Wears a removable orthodontic appliance?	☐	☐
2. Ever been hospitalized?	☐	☐	12. Skin problems?	☐	☐
3. Frequent headaches?	☐	☐	13. Mononucleosis in the past 12 months?	☐	☐
4. A head injury?	☐	☐	14. Problems with diarrhea/constipation?	☐	☐
5. Knocked unconscious?	☐	☐	15. Sleepwalking?	☐	☐
6. Passed out during or after exercise?	☐	☐	16. If female, abnormal menstrual history?	☐	☐
7. Been dizzy during or after exercise?	☐	☐	17.History of bed-wetting?	☐	☐
8. Had chest pain during or after exercise?	☐	☐	18. Ever had an eating disorder?	☐	☐
9. Diagnosed with a heart murmur?	☐	☐	19. ADD/ADHD?	☐	☐
10. Back problems?	☐	☐	20. Ever had emotional difficulties for which professional help was sought?	☐	☐

Please explain "yes" answer(s), 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 your camper's needs.

_____

_____

_____

_____

E. 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).*

_____

_____

_____

_____

F. Health Examination Record for Wisconsin United Methodist Special Needs Camps

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.

Camper Name _____ Birth Date _____ Sex_____ Age_____

Height: _____ Weight: _____ Blood Pressure: _____

Allergies: *(list allergens)*

Environmental _____ Food: _____ Latex: _____
Medicines: _____ Insect stings/bites: _____ Other: _____

Immunizations dates (*record may be attached.)*

Tetanus _____ Measles _____ Mumps _____ German Measles _____ Chicken Pox _____
Rubella _____ Hepatitis A _____ Hepatitis B _____ Hepatitis C _____ Polio _____ Whooping Cough _____

Health History:

Yes	No		Yes	No		Yes	No	
☐	☐	Asthma	☐	☐	Chest pain	☐	☐	Frequent ear infections
☐	☐	Blindness/visual problem	☐	☐	Diabetes	☐	☐	Deaf/complete hearing loss
☐	☐	Bleeding/clotting disorders	☐	☐	Hearing impaired	☐	☐	Major surgery or serious illness
☐	☐	HIV/ARS	☐	☐	Heart disease/defect/high blood pressure	☐	☐	IBS
☐	☐	Bone/joint problem	☐	☐	Heat stroke/exhaustion	☐	☐	Crohn's
☐	☐	Emotional/psychiatric/behavioral	☐	☐	Seizures/epilepsy/fainting spell	☐	☐	Colitis
If yes, explain _____			Type: _____			☐	☐	Special Diet _____
						☐	☐	Other _____

Please describe all that are answered *YES:*_____

_____

_____

_____

_____

Diagnoses of any current, chronic, or recurring conditions/illnesses *(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) _____

☐ Complete rest (restricted to sitting/walking) _____

☐ One-to-one Supervision for all bathing and water activities _____

Physical Examination

Normal	Abnormal		Normal	Abnormal		Normal	Abnormal	
☐	☐	Vision	☐	☐	Cardiovascular System	☐	☐	Cranial nerves
☐	☐	Hearing	☐	☐	Respiratory System	☐	☐	Coordination
☐	☐	Oral Cavity	☐	☐	Gastrointestinal System	☐	☐	Reflexes
☐	☐	Neck	☐	☐	Genitourinary system	Other: _____		
☐	☐	Extremities	☐	☐	Skin/scalp			

Primary MR Etiology/Category (if known) _____

I have reviewed the above health history and have performed the above examination on this individual within the 12 months and certify that they are able to participate in camp activates.

_____ _____ _____

Signature/Examining Physician: Print Physician's Name Date

H. MEDICATION AUTHORIZATION

Camper Name: ________________________________ Birth Date:____________ Camp dates__________________

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:

Please keep all medications (prescription or over-the-counter) in original containers. Blister packs welcomed.
ALL medications should be listed on this form (or pharmacy printout included) 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:____

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.

G. 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