FORT WILDERNESS

Fort Wilderness Ministries
Health History Form

P.O. Box 715
McNaughton, WI 54543
(715) 277-2587 Fax (715) 277-3928

Revised: 4/15/2013

Name of camp attending: _____

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp.

Complete information is needed so that the camp can be aware of your needs.

Name:_____ Birth date _____/_____/_____ Age at camp _____
Last *First* *Middle*

Home address _____
Street address *City* *State* *Zip*

Social Security Number of Camper: _____ - _____ - _____ (Medical or Hospital use only) Gender: ___ Male ___ Female

Custodial parent / guardian: _____ Phone: (____) ____ - _____

Home address_____
(if different from above) Street address *City* *State* *Zip*

Business address: _____ Phone: (____) ____ - _____
Street address *City* *State* *Zip*

Second parent or guardian or emergency contact: _____

Address: _____ Phone: (____) ____ - _____
Street address *City* *State* *Zip*

Business address: _____ Phone: (____) ____ - _____
Street address *City* *State* *Zip*

If not available in an emergency, notify: _____

Relationship: _____ Phone: (____) ____ - _____

Address: _____
Street address *City* *State* *Zip*

Insurance Information

Is the participant covered by family medical/hospital insurance? ___ Yes ___ No Subscriber's SS Number: _____ - _____ - _____

Responsible Party's Name : _____ Subscriber's DOB: _____ - _____ - _____

If so, indicate carrier or plan name: _____ Group/Policy # _____

► ***Photocopy of front and back of health insurance card must be attached to this form.***

Important – These boxes must be complete for attendance*

Parent /Guardian Authorizations: I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays, CAT scans, blood work or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp. The following Medical Director approved medications are available via appointed Health Staff and will be administered per recommended doses as needed. **EPI-PEN**(for severe allergic reaction), **Diphenhydramine** (as needed for hives, itching or localized rashes), **Acetaminophen or Ibuprofen** (for headache, fever, or cramps), **Loperamide** (for diarrhea) , **Antacids** (for upset stomach or heartburn) **Antihistamine (**for nasal congestion.) **This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities as noted.**

Signature of parent or guardian or adult camper/staffer: _____

Printed Name: _____ Date: _____ / _____ / _____

Yes / No I wish to be notified if my child sees the camp nurse or medical staff for any reason.

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

Medication allergies (list)

_____ _____
_____ _____
_____ _____

Food allergies – see additional form to complete

Other allergies (list) – include - stings, hay fever, asthma, animal dander, etc.

_____ _____
_____ _____
_____ _____

Restrictions (The following restrictions apply to this individual.)

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

Medications Being Taken
Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packing/bottle that identifies the prescribing physician (if a prescription), the name of the medication, the dosage, and the frequency of administration.

___This person takes **NO medications** on a routine basis. OR ___This person **takes medications** as follows:

Med #1 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____

Med #2 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____

Med #3 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____

Med #4 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____

Attach additional pages for more medications.
Identify any medications taken during the school year that participant does/may not take during the summer: _____

General Questions (Explain "yes" answers below.)

Has/does the participant:	Yes	No		Yes	No
1. Had any recent injury, illness or infectious disease?	__	__	15. Ever been diagnosed with a heart murmur?	__	__
2. Have a chronic or recurring illness/condition?	__	__	16. Ever had back problems?	__	__
3. Ever been hospitalized?	__	__	17. Ever had problems with back, knees, ankles ?	__	__
4. Ever had surgery?	__	__	18. Have an orthodontic appliance being brought to camp?	__	__
5. Have frequent headaches?	__	__	19. Have any chronic skin problems (e.g. itching, rash, acne)?	__	__
6. Ever had a head injury?	__	__	20. Have diabetes?	__	__
7. Ever been knocked unconscious?	__	__	21. Have asthma?	__	__
8. Wear glasses, contacts or protective eyewear?	__	__	22. Had mononucleosis in the past 12 months?	__	__
9. Ever had frequent ear infections?	__	__	23. Had problem with diarrhea/constipation?	__	__
10. Ever passed out during or after exercise?	__	__	24. Have problems with sleepwalking?	__	__
11. Ever been dizzy during or after exercise?	__	__	25. If female, have an abnormal menstrual history?	__	__
12. Ever had seizures?	__	__	26. Have a history of bed-wetting?	__	__
13. Ever had chest pain during or after exercise?	__	__	27. Ever had an eating disorder?	__	__
14. Ever had high blood pressure?	__	__	28. Ever had emotional difficulties for which professional help was sought?	__	__

Please explain any "yes" answers, noting the number of the questions. _____
_____
_____
_____

Which of the following has the participant had?

__ Measles
__ Chicken pox
__ German measles
__ Mumps
__ Hepatitis A
__ Hepatitis B
__ Hepatitis C

TB Mantoux Test
Date of last test: _____
Result: __ Positive __ Negative

Please give all dates of immunization or attach a copy of immunization record:

Vaccine:	Dates: Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP	_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)	_____	_____	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____	
MMR	_____	_____				
or Measles	_____	_____				
or Mumps	_____	_____				
or Rubella	_____	_____				
Haemophilus influenza B	_____	_____	_____	_____		
Hepatitis B	_____	_____	_____			
Varicella (chicken pox)	_____	_____				

Immunizations are not mandatory to attend camp.

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. _____
_____

Name of family physician: _____ Phone: (____) ____ - _____
Address: _____
Name of family dentist/orthodontist Address: _____ Phone: (____) ____ - _____

Screening Record (For camp use only) Screened by _____

Date screened: _____ Time: _____ am / pm Updates/additions to health history noted: Yes No None required

Meds received: _____
Current health needs identified: _____
Observational notes: _____