WISCONSIN UNITED METHODIST Camp & Retreat ministries

Youth Health Form

Camp Site _____

Camp Name and Number _____

Directions: Please use 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.

A. Camper & Parent Information

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. Care Providers

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).

C. Medical Consent

MEDICAL CONSENT AGREEMENT

Participant's Name:_____

CERTIFICATION AND CONSENT TO AUTHORIZE MEDICAL CARE FOR MINOR. 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
1. Have any recent injury, illness or infectious disease? .	Y / N
2. Have a chronic or recurring illness/condition? ……	Y / N
3. Ever been hospitalized? …….	Y / N
4. Ever had surgery? ……	Y / N
5. Have frequent headaches? ……	Y / N
6. Ever have a head injury? …….	Y / N
7. Ever been knocked unconscious? ……	Y / N
8. Wear glasses, contacts, or protective eye wear? ……..	Y / N
9. Ever had frequent ear infections? ……	Y / N
10. Ever passed out during or after exercise? ……	Y / N
11. Ever been dizzy during or after exercise? ……	Y / N
12. Ever had seizures?…….	Y / N
13. Ever had chest pain during or after exercise? ……...	Y / N
14. Ever had high blood presure? ……...	Y / N
15. Ever had bleeding/clotting disorder? ……	Y / N
16. Ever been diagnosed with a heart murmur? ..	Y / N
17. Ever had back problems? …….	Y / N
18. Ever had problems with joints? ……	Y / N
19. Wear a removable orthodontic appliance? …	Y / N
20. Have any skin problems? ……..	Y / N
21. Have diabetes? ……..	Y / N
22. Have asthma? ……	Y / N
23. Had mononucleosis in the past 12 months? ..	Y / N
24. Had problems with diarrhea/constipation? …	Y / N
25. Have problems with sleepwalking? ……..	Y / N
26. If female, abnormal menstrual history? …….	Y / N
27. Have a history of bed-wetting? ……..	Y / N
28. Ever had an eating disorder? ……..	Y / N
29. Ever had emotional difficulties for which 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 adaptions or limitations are necessary).

_____

_____

_____

G. Immunization History

Which of the following has the participant had?

- ☐ Measles
- ☐ German measles
- ☐ Chicken pox
- ☐ Mumps
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ TB Mantoux test

Date of last test _____

Result: ☐ Positive ☐ Negative

Please give all dates of immunizations:

	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
Tetanus	_____	_____	_____	_____	_____	_____
DTP	_____	_____	_____	_____	_____	_____
TD (tetanus/diptheria)	_____	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____	_____
MMR	_____	_____	_____	_____	_____	_____
or Measles	_____	_____	_____	_____	_____	_____
or Mumps	_____	_____	_____	_____	_____	_____
or Rubella	_____	_____	_____	_____	_____	_____
Haemophilus Infuenza B	_____	_____	_____	_____	_____	_____
Hepatitis B	_____	_____	_____	_____	_____	_____
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.)