Wisconsin 4-H Camp Health Form

UW–MADISON EXTENSION

Event Name: _____

Dates: _____

PARTICIPANT'S PERSONAL INFORMATION *(please print)*

FIRST NAME:	MIDDLE INIT.:	LAST NAME:	BIRTHDATE (Mo/Day/Yr.):	SEX:	PRIMARY PHONE NUMBER:

MAILING ADDRESS STREET:	CITY:	STATE:	ZIP:

NAME OF PRIMARY PARENT/LEGAL CUSTODIAN IN CASE OF ILLNESS OR INJURY:	WORK TELEPHONE NUMBER:	CELL PHONE NUMBER:

NAME OF SECOND PARENT/LEGAL CUSTODIAN IN CASE OF ILLNESS OR INJURY:	WORK TELEPHONE NUMBER:	CELL PHONE NUMBER:

PARTICIPANT'S HEALTH CARE PROVIDER INFORMATION

HEALTH CARE PROVIDER NAME:

MEDICAL FACILITY NAME:	TELEPHONE NUMBER:

☐ This participant has no known allergies.

☐ This participant is allergic to this food(s):	■ Does this allergy cause anaphylaxis? ☐ Yes ☐ No
☐ This participant is lactose intolerant.	☐ This participant is gluten intolerant.

☐ Other *(please explain):*

☐ This participant is allergic to medication(s):	☐ Environment (insect stings, hay fever, etc)	☐ Other:

Please describe below what this participant is allergic to and the reaction seen:

MEDICATION

☐ This participant will NOT take any prescription medications while attending camp.

☐ This participant will take the following prescription medication(s) while attending camp. I am bringing enough medication to last the entire session and it is in the original container labeled by the pharmacy. (If more space for medications is needed, staple another page with additional medications to the end of the form.)

Name of Medication	Amount or Dose Given	Reason for Taking It	When It Is Given	How It Is Given	Emergency Medication Only Legal Guardian to initial below if camper is **able to carry and self-administer** (i.e inhaler, epi-pen)
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time: _____		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time: _____		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time: _____		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time: _____		

			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time: _____		

MEDICAL INSURANCE INFORMATION:

The participant is covered by family medical/hospital insurance. ☐ Yes ☐ No	
Insurance Company:	Policy Number:
Subscriber:	Insurance Company Phone Number:

ASTHMA

☐ This participant **does NOT** have asthma.	☐ This participant **does** have asthma.

Asthma Triggers (check all that apply)		Signs/Symptoms of asthma episode	Frequency of episodes	How episode is managed
☐ Exercise	☐ Colds			
☐ Infections	☐ Emotions			
☐ Allergies (to what?)				
☐ Weather (what type?)				
☐ Other (list)				

IMMUNIZATIONS

List the MONTH, DAY, AND YEAR your child received each of the following immunizations. DO NOT USE (√) OR (X) except to answer the question about chickenpox, Tdap or Td. If you do not have an immunization record for this child at home, contact your doctor or public health department to obtain it. A copy of the child's complete immunization record from the WIR may be attached to this form http://www.dhfswir.org or from healthcare providers, state, or local government are also acceptable.

TYPE OF VACCINE*	FIRST DOSE Mo/Day/Yr	SECOND DOSE Mo/Day/Yr	THIRD DOSE Mo/Day/Yr	FOURTH DOSE Mo/Day/Yr	FIFTH DOSE Mo/Day/Yr
DTaP/DTP/DT/Td (Diphtheria, Tetanus, Pertussis)					
Adolescent booster (Check appropriate box) ☐ Tdap ☐ Td					
Polio (IPV)					
Hepatitis B					
MMR (Measles, Mumps, Rubella)					
Varicella (Chickenpox) Vaccine Vaccine is needed only if your child has not had Chickenpox disease.			Has your child had Varicella (chickenpox) disease? ☐ Yes, year: ☐ No or Unsure (vaccine needed)		

☐ For health reasons, this child is not fully immunized.
☐ For personal conviction or religious reasons, this child is not fully immunized. **Include any immunizations received above.*

RESTRICTIONS:

☐ I have reviewed the program and activities of the event and feel the participant can participate without restrictions.

☐ I have reviewed the program activities of the event and feel the participant can participate with the following restrictions or adaptations *(Please describe below):*

OTHER CAMPER CONSIDERATIONS

PLEASE INDICATE ANY OTHER IMPORTANT MEDICAL CONDITIONS
(eg. Diabetes; seizures; physical conditions; non-prescription medications not to be given; mental, emotional, or social health)

SIGNATURE

This health history is correct and accurately reflects the health status of the participant. The person described has permission to participate in all event activities except as noted by me or an examining physician. I give permission to the event to provide routine healthcare services, administer medications, and seek emergency services.

SIGNATURE – Parent/Guardian/Legal Custodian _____ DATE _____

CONSENT FOR MEDICATION ADMINISTRATION AND MEDICAL TREATMENT

TO THE PARENT(S) OR LEGAL GUARDIAN:

If your son, daughter, or ward will be under the age of 18 while participating in a University of Wisconsin – Madison Division of Extension event/camp/program, it is event/camp/program policy to secure your consent for medication distribution and for the use of medical devices. The medication or medical device must be administered by designated event/camp/program health staff with the exception that a limited amount of medication for life-threatening conditions may be carried and administered by my son/daughter/ward (i.e. bee sting kit, inhaler, insulin syringe).

It is event/camp policy to secure your consent for medication distribution and for the use of medical devices by signing below.
Please check all that apply:

Yes	No		
☐	☐	Medication(s) has been brought to event/camp.	
☐	☐	Prescription medication(s) has been brought to event/camp. All prescription medication must be in the original medicine bottle and labeled with the youth participant's name, doctor's name, medication name, dosage, prescription number, date prescribed, and instructions. Also, information about any prescription medications must be provided in writing to event/camp health staff with the information requested in the later section of this form.	
☐	☐	Over-the-counter medications may be administered by event/camp health staff as needed. The following prescription medications may NOT be administered by event/camp health staff:	

If your son, daughter, or ward will be under the age of 18 years while at the event/camp, it is our policy to secure your consent for **all of the following**. By signing below,

- I am giving my consent in advance for medical treatment at an appropriate medical facility in case of illness or injury.
- I am stating that I am aware of and accept the risk inherent in the program activity.
- I attest that all information on this form is correct and up-to-date, and that I will provide any and all significant material, and important changes to any information in this form to event/camp staff no later than check-in.

Participant Name (Please Print)

SIGNATURE OF PARENT OR LEGAL GUARDIAN **Date**

This is the approved health form for 4-H events and camps.