Wisconsin 4-H Camp Health Form Addendum

UW–MADISON EXTENSION

Event Name: _____

Dates: _____

Participant Name: _____ Birth Date: _____

Parent/Guardian: _____ E-mail address: _____

Phone Numbers: Home _____ Phone Numbers: Cell _____

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.*

ADDITIONAL MEDICATIONS NOT PREVIOUSLY LISTED

☐ This participant will take the following 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: _____		

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