

Easter Seals Wisconsin Camp Wawbeek Health History & Examination Form 2012

If you are a minor, the form must be completed by a parent or guardian. This information must be updated **annually** and is used by Easter Seals health care personnel to assure that each camper receives the best possible care.

PLEASE NOTE: The last section must be completed by a licensed physician or nurse practitioner. Please keep a copy of this form for your records and notify us of any changes.

Gender: Male Female

Name: _____ Birth date: _____ Age at camp: _____

Custodial Parent/Guardian: _____ Relationship: _____

Custodial Parent Home Phone: _____ Cell Phone: _____ Other Phone: _____

If you cannot be reached in an emergency, please list whom to notify in order of preference:

#1

Name: _____ Relationship: _____
Home Phone: _____ Cell Phone: _____ Other Phone: _____

#2

Name: _____ Relationship: _____
Home Phone: _____ Cell Phone: _____ Other Phone: _____

#3

Name: _____ Relationship: _____
Home Phone: _____ Cell Phone: _____ Other Phone: _____

Primary Medical Diagnosis: _____

Secondary Medical Diagnosis: _____

Allergies—List all known and describe reaction

Medication Allergies: _____

Reaction: _____

Food Allergies: _____

Reaction: _____

Other Allergies (i.e. insect stings, animals, environmental, etc.): _____

Reaction: _____

Seizure History

Has the camper ever had a seizure or convulsion? Yes, Date of last seizure: _____ No

Type of Seizure: _____

Frequency of Seizures: _____ Length of Seizures: _____

Known Triggers: _____

PRN Medications Available (for seizures): _____

Protocol for PRN use at camp: _____

Dietary Restrictions

Any special diet while at camp: Yes No Type: _____

Any Dietary restrictions: _____

Bringing campers own food: Yes No

**THIS FORM MUST BE RECEIVED AT LEAST 2 WEEKS PRIOR TO YOUR SESSION DATE.
PLEASE SEND TO EASTER SEALS WISCONSIN, 101 NOB HILL RD STE 301, MADISON WI 53713.**

Name: _____

All prescription medications must be brought to camp in their original pill BOTTLES from the pharmacy. Medications in any other containers, including bubble packs and pre-sets (or pill organizers), *will not be accepted*. All pill bottles must be PROPERLY LABELED WITH CAMPER NAME (including over the counter medications) AND THE CURRENT DOSAGE. Though bubble packs may be the dispensing mode at some facilities, the camper's pharmacist will, if asked, transfer the medications for the camp duration into properly labeled bottles. Please bring the required supply for the days staying at camp PLUS 1 extra day.

| Does the camper have a history of: | | Yes | No | Does the camper have a history of: | | Yes | No |
|------------------------------------|--|-----|----|------------------------------------|---|-----|----|
| 1 | Asthma | | | 15 | Frequent Headaches | | |
| 2 | Frequent Colds | | | 16 | Frequent Ear Infections | | |
| 3 | Heart Disorder or Disease | | | 17 | Stomach Disorders | | |
| 4 | Episodes of Passing Out | | | 18 | Diarrhea | | |
| 5 | Bleeding Disorders | | | 19 | Constipation | | |
| 6 | Blood Disorders | | | 20 | Abnormal Menstrual Cycles | | |
| 7 | Hepatitis A, B, or C | | | 21 | Problems with Joints | | |
| 8 | Diabetes | | | 22 | Chronic or Recurrent Illnesses | | |
| 9 | Skin Problems (rashes, itching) | | | 23 | Past or Recent Surgeries | | |
| 10 | Skin Breakdown (bed sores) | | | 24 | Past or Recent Hospitalizations | | |
| 11 | Eating Disorder | | | 25 | Problems Sleeping | | |
| 12 | Emotional Difficulty (for which professional | | | 26 | Adaptive Equipment (braces, wheelchair, walker, | | |
| 13 | Head injury | | | 27 | Other: | | |
| 14 | Chicken Pox | | | 28 | Other: | | |

Please explain any "yes" answers from above. List the number before explanation. _____

Insurance Information: *Please attach a copy of applicant's insurance card.*

Family Medical/Hospital Insurance Carrier: _____ Group: _____

Policy #: _____ Medicaid #: _____ Medicare #: _____

Physician: _____ Hospital: _____

The information on this form is accurate and complete to the best of my knowledge. The person herein described has permission to engage in all camp activities except as noted. I hereby give permission to Easter Seals to provide routine health care under the guidance of the camp's medical director, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

I give permission to Easter Seals to arrange necessary related transportation for the person named above. 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.

Signature of Parent/Guardian or Adult Camper: _____ Date: _____

Printed Name: _____

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Health Care Recommendations

To be completed by Licensed Medical Personnel (Physician or Nurse Practitioner)

Please list the applicant's primary physician if different from the licensed medical personnel filling out the form.

Camper Name: _____

Primary Physician: _____ Phone #: (____) _____

I examined this individual on ___/___/____. Easter Seals Wisconsin requires **annual exams. A new exam is not necessary if you have a copy of a current and comparable physical form used for another camp/program.**

BP: _____ Pulse: _____ Weight: _____ Height: _____

Record of immunizations (if obtainable) and date of last tetanus shot: _____

Description of any camp activity restrictions: _____

Additional health information: _____

Any medically prescribed meal plans or dietary restrictions: _____

Free of Communicable Disease as of _____

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which camp staff should be made aware.

I have examined the herein named individual and have reviewed the health history and find this person to be free of any contagious disease. I find this individual able to participate in a camp experience with the previously listed limitations.

Signature of Licensed Medical Personnel _____ Date _____

Printed Name _____ Title _____

Address _____

Phone _____ Fax _____

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