

## University of Wisconsin – Stevens Point Camp Health Form

Camp Name:	
Dates of Camp:	

INS T					
Camper Name	Birth date		Age on 1 <sup>st</sup> day of camp	Male	Female
Custodial Parent/Guardian (or s	pouse)		E-mail address:		
Phone Numbers: Home	one Numbers: Home Work		Cell phone		
Home address:					
	Street	City	State	Э	Zip
Other emergency contacts:			Phone:		
			Phone:		
Address:					
St	reet	City	State		Zip
CONSEN	NT FOR MEDICATION ADMI	NISTRATION	AND MEDICAL TREATMEN	NT	
TO THE PARENT(S) OR LE	GAL GUARDIAN:				
camp. You do not need to be prescription and over the coulabeled with the camper's na dosage, prescription number,	the counter medications (for few ring these to camp, unless your anter medications must be in the me. Prescription medications and date prescribed, and instruction	r child needs a ne <u>original me</u> must <b>also</b> hav ons. Please ind	specific over the counter med edicine bottle (see picture at rige the prescribing doctor's nam licate your wishes for your child	ication. All ght) or packag e, medication ld in the follow	ge, and name,
	inistration of over the counter med er, sunburn, indigestion, cold sym				
of the following. By signing	d will be under the age of 18 y g below, it in advance for medical treatmen				for <b>all</b>
I am giving consent for	r administration of basic medical	evaluation and	treatment by camp health staff for	r minor illness (	or injury.
I am stating that I am a	ware of and accept the risk inhere	ent in the progra	am activity.		
I attest that all informa	tion on both sides of this form is	correct.			
Wisconsin – Stevens P	es and indemnify the Board of Regoint, their officers, agents, and encurred or required arising out of t	nployees from a	any and all liability, loss, damages	s, costs, or expe	enses
Signature of Parent or	Guardian		Date		

Signature of Camp Participant (if over age 18) \_\_\_\_\_\_ Date \_\_\_\_\_

Camp	per Name						
UW	UWSP Camp Medical History Form		m	Health Plan/Policy #			
My Child Has These Health Conditions:  Asthma Diabetes Epilepsy Any dizziness, light-headedness or fainting associated with exercise within the past year		Alle	Foods Medications	pecifics):			
<u> </u>	<ul> <li>Any unexplained, rapid or irregular heart beat within the past year, or heart condition</li> <li>A physician has denied or restricted participation in</li> </ul>			<b>Do any allergies require an EPIPEN Injection?</b> Yes  No  No  Date of last Tetanus booster :			
Desc and/o	sports due to a health is ription of any limitation or current treatment for l	or restriction of camp	activities				
child		amp (include circumsta	ances when phy	ysician	should be notified)?	vailable at camp, no need to bring these):	
N:	ame of Medication	Reason	Dosage (mg	g)	Times of day given	Prescribing Physician & Phone Number	
	Does the camper experient of the camper experient to the camper experience of the camper experie	ence any side effects fr	om the medica	ation? (	i.e., mood/behavior c	changes, upset	
2. I	List any special instructi	ons or additional infor	mation regardi	ng the	medication that wou	ld be helpful to the Health Care staff:	
1.	*** FOR CAMP U					RE STAFF AT CHECK-IN ***	
2.		n your family been sick or	exposed to any co	ommuni	cable disease in the past	month? □ No □ Yes	
	Has your child, or anyone in						
	Has your child, or anyone in Does your child now have a		□ No □ Ye	es			
3.		any rashes or open sores?			anges . & sign) 🚨 No	)	
<ol> <li>4.</li> </ol>	Does your child now have a	any rashes or open sores?	ns? (If <b>Yes</b> , Staff n	make ch	anges . & sign) □ No	) □ Yes	
<ul><li>3.</li><li>4.</li><li>5.</li><li>6.</li></ul>	Does your child now have a Are there any changes in you Does your child have any re Will the custodial parent(s)	any rashes or open sores?  our dependent's medication ecent injury or activity rest	ns? (If Yes, Staff n trictions?	make characters are the contracted on the	Yes is form during the campi		
<ul><li>3.</li><li>4.</li><li>5.</li><li>6.</li></ul>	Does your child now have a Are there any changes in yo Does your child have any re Will the custodial parent(s) If NO, list the name & phor side of this form:	any rashes or open sores?  our dependent's medication ecent injury or activity rest	ns? (If Yes, Staff n trictions?	make character c	Yes is form during the campi	ing session?  No Yes ent than the emergency contact listed on the reverse	