EpiscoWisco Youth Fall Lock-In
Health History Form Student/Adult

Bring to event check-in (Do NOT return before event)
✓ This form (completed) ✓ Copy of Insurance Card
✓ Any medications currently taking in original containers

2024

Full Name _____ Birth Date _____/_____/_____ Age at Camp _____

Mailing Address _____
Street *City* *State* *ZIP*

Custodial parent/guardian (adults leave blank)	*Other parent/guardian or contact (adults leave blank)*	*If neither available, emergency contact (adults – complete)*
_____ *Name*	_____ *Name*	_____ *Name*
Cell Phone (_____) _____	Cell Phone (_____) _____	Cell Phone (_____) _____
Work Phone (_____) _____	Work Phone (_____) _____	Work Phone (_____) _____

Insurance – Is this camper / staff member covered by medical insurance? ❑ Yes ❑ No

Carrier name and phone _____ (_____) _____
Group / Policy number _____ Name of insured _____

Health History – *parent, legal guardian, self (if an adult), physician or nurse practitioner may complete.*
Physician name & phone _____ (_____) _____
This person under care for: _____

_____

_____

Has had tetanus shot? ❑ Yes ❑ No Date of last shot/ booster _____

Has had chicken pox? ❑ Yes ❑ No Has had mononucleosis in the past 12 months? ❑ Yes ❑ No

Has a history of illness, injury or surgery that will affect participation? ❑ Yes ❑ No If yes, explain:

_____

_____

_____

_____

Other Concerns: Check those that pertain. Provide information about supportive healthcare procedures used.

- ❑ No other health concerns
- ❑ Emotional, learning and / or psychological concerns
- ❑ Other health concerns
  - ❑ Asthma ❑ Headaches ❑ Sleepwalking ❑ Diabetes ❑ Recent headlice
  - ❑ Menstrual cramps ❑ Frequent ear infections ❑ Bedwetting ❑ Other _____

Procedures followed? _____

_____

_____

Allergies Reaction and management
Medication allergies

_____ _____

_____ _____

Food / other allergies (insect stings, hay fever, asthma, animal dander, etc…)

_____ _____

_____ _____

(Over)

Name _____
Session(s) Senior Middler Junior Kinder Staff or CIT

DIET: ❑ Gluten free ❑ Vegetarian ❑ Lactose Intolerant ❑ Nut Allergy ❑ Seafood Allergy
❑ No red meat ❑ No pork ❑ No eggs ❑ No poultry

❑ Other _____

MEDICATIONS

❑ This person takes **NO** regular medications. Or ❑ This person **TAKES** regular medications.

List **All** medications taken routinely, including over the counter / nonprescription. **Bring** dosage for entire camp in original bottle / packaging which identifies name of medication, dosage, and frequency. Prescriptions must identify prescribing physician. Dispensed according to label instructions. If not taking as indicated, get into properly labeled container for current dosage.
Campers are not allowed to self-medicate, except by necessity (*i.e. inhalers and the like*).

Medication _____ Dosage _____ Daily ❑ Yes ❑ No
Reason _____ Date started_____

Medication _____ Dosage _____ Daily ❑ Yes ❑ No
Reason _____ Date started_____

Medication _____ Dosage _____ Daily ❑ Yes ❑ No
Reason _____ Date started_____

Medication _____ Dosage _____ Daily ❑ Yes ❑ No
Reason _____ Date started_____

- - - List additional medications on a separate sheet - - -

_____

Person completing form_____ Date _____

AUTHORIZATIONS

Initials (parent for minors, self if adult)

_____ I authorize an adult in whose care this camper or staff member has been entrusted to consent to X-ray examination, anesthetic, medical, surgical, or dental diagnosis and treatment or hospital care, to be rendered under the supervision and on the advice of any physician or dentist licensed under the provisions of the medical practice act if there is insufficient time or inability to contact the emergency contact. I will be liable and agree to pay all costs and expenses incurred in connection with services rendered pursuant to this authorization.

_____ I give permission for this camper or staff member to ride in any vehicle designated by the adult in charge.

_____ I will take no civil action against EpiscoWisco Camp, the Episcopal Diocese of Wisconsin associated agencies, or persons in whose care the student/adult has been entrusted for normal care.

_____ If this student or adult has a headache, _____ *(example: Tylenol, Ibuprofen, etc…)* is usually given.

_____ I give permission for this student or adult to receive non-prescription medications for non-emergency situations from a designated healthcare provider.

Signature of Parent / Legal Guardian / Self (*if adult*)_____ Date _____

EVENT USE
Nursing Notes

_____

_____

_____

_____

_____

_____

_____

Screening performed by_____ Date _____