

# EpiscoWisco Camp

## Health History Form

### Camper / Staff

**Bring to camp check-in** (Do NOT return before camp)  
 ✓ This form (completed)    ✓ Copy of Insurance Card  
 ✓ Any current medications in original labeled containers

# 2025

Full Name \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age at Camp \_\_\_\_\_

Mailing Address \_\_\_\_\_  
Street City State ZIP

<i>Custodial parent/guardian (adults leave blank)</i>	<i>Other parent/guardian or contact (adults leave blank)</i>	<i>If neither available, emergency contact (adults – complete)</i>
<small>Name</small> _____	<small>Name</small> _____	<small>Name</small> _____
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 / \_\_\_\_\_ Name of \_\_\_\_\_  
 Policy number \_\_\_\_\_ 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 \_\_\_\_\_  
 Middle \_\_\_\_\_  
 Junior \_\_\_\_\_  
 Kinder \_\_\_\_\_  
 Staff or CIT \_\_\_\_\_

**DIET:**  Gluten free     Vegetarian     Lactose Intolerant     Nut Allergy     Vegan     Seafood Allergy  
 No red meat     No pork     No eggs     No poultry     Pescetarian  
 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 & relationship to camper \_\_\_\_\_

**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, associated agencies, or persons in whose care the camper or staff member been entrusted for normal care.

\_\_\_\_\_ If this camper or staff member has a headache, \_\_\_\_\_ (*example: Tylenol, Ibuprofen, etc...*) is usually given.

\_\_\_\_\_ I give permission for this camper or staff member to receive non-prescription medications for non-emergency situations from a designated healthcare provider.

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

**CAMP USE  
Nursing Notes**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Screening performed by \_\_\_\_\_ Date \_\_\_\_\_