University of Wisconsin-Stout
University Conference Coordinator - Memorial Student Center–Room 213
(715) 232-5132 Fax: (715) 232-1432

Health History Questionnaire
for Summer Camps/Programs

Completion of both sides of form is REQUIRED prior to participation (HFS 175)

CAMP EVENT:____

CAMP DATES: ____

Participant:____
Last First MI

Date of Birth: ____/____/____ (M D Y) Sex: ❑ Female ❑ Male Height: _______ Weight: _______ Age_________

Home Address:____

City: ______________________ ________________ State: __________ Zip: ____________

Home Telephone Number: ________________________ Cell/Mobile Number: ____________________

Has participant had or is presently experiencing: *(Please check ✔ all that apply) explain below*

Yes	No		Yes	No		Yes	No	
❑	❑	Allergies	❑	❑	Epilepsy/Seizures/Blackouts	❑	❑	Menstrual Difficulties
❑	❑	Seasonal Allergies	❑	❑	Heart Disease	❑	❑	Mental/Emotional Problems
❑	❑	Asthma	❑	❑	Bleeding Disorder	❑	❑	Hernia
❑	❑	Neck/Back Pain/Injury	❑	❑	Cancer	❑	❑	High Blood Pressure
❑	❑	Rheumatic Fever	❑	❑	Colitis	❑	❑	Joint Injury/Surgery
❑	❑	Tuberculosis	❑	❑	Diabetes	❑	❑	Kidney Disease
❑	❑	Ulcer						

Please explain all ✔____

Does participant take medication on a regular basis? ❑ Yes ❑ No If yes, identify________________________
(Consent for medication administration must be signed on reverse side)

Does participant have allergic reactions to:

Yes	No		Yes	No	
❑	❑	Penicillin	❑	❑	Other Antibiotics ________________
❑	❑	Other Medicine (type) ______________	❑	❑	Insect Bites/Stings ________________
					(EPI Pen - Required ❑ Yes ❑ No)

Immunization Record

MMR *(measles, mumps, rubella)*

* Dose 1 - given at age 12-15 months or later ____/____/____ (M D Y) * Dose 2 - given at age 4-6 years or later ____/____/____ (M D Y)

Tetanus-Diptheria *(initial series completed)* ____/____/____ (M D Y) and at least 4 weeks after first dose.

Last date of tetanus booster (Preferably within last 10 years) ____/____/____ (M D Y)

Has participant ever had major surgery or been hospitalized? ❑ Yes ❑ No If yes, explain:________________________

____

Please explain any significant operations, accidents or illnesses, and last medical attention and reason:________________

____

____

Does the participant have any physical condition(s) requiring special considerations? Explain.

____

____

A physical examination within 24 months of the camp/event is recommended. Date of participant's last physical examination:

____

Medical Treatment and Medication Administration Consent Form

Completion of both sides of form is REQUIRED prior to participation (HFS 175)

Participant: ____________________

Parent/Guardian: ____________________

Home Telephone: ____________________ Work Telephone: ____________________

Cell/Mobile Telephone: ____________________

Name of Physician: ____________________ Telephone: ____________________

Name of Insurance: ____________________ Policy #: ____________________

Alternative contact in the event that the Parent/Guardian cannot be contacted in the case of an emergency (injury/illness) involving the participant named above.

Name: ____________________ Relationship: ____________________ Telephone: ____________________

If your son, daughter or ward will be under the age of 18 years while at the University of Wisconsin-Stout, it is policy to secure your consent for medical treatment and medication distribution, whether medication/treatment is self-administered or administered by designated camp staff.

All medications must be in *original or separate medicine bottles and labeled with the camper's name.* Prescription medication(s) must also include on the label *doctor's name and phone number, medication name and dosage.*

❑ **No** medication brought to camp.

❑ **Yes**, non-presecription/over the counter medications are being brought to camp. Non-prescription/over the counter medication can be self-administered. Please indicate the name of the medication(s), dosage, and reason for taking the medication:

____

If camper is **NOT** allowed to self-administer non-prescription/over the counter medications, sign here:

____

❑ **Yes,** prescription medication(s) and/or medical device(s) are brought to camp. *Complete medication box below.*

❑ **Yes,** I will self-administer the medication(s) and/or medical device(s). ***This is allowed if 14 years old or older.***

❑ Designated camp staff, i.e. nurse, athletic trainer, camp counselor, will administer the medication(s) and/or medical device(s). ***Mandatory for age 13 and under.***

*** However, a limited amount of medication for life threatening conditions may be carried by my son/daughter/ward, i.e. allergy medications, bee sting kits, inhalers, insulin.*

Name of Medication and prescribing MD	Dosage	How is it taken, i.e. oral, injection	Time(s) of day medication is taken	Day(s)/Number of days medication is to be taken

Special Instructions: ____________________

____

By signing below, you are:

- Giving your consent in advance for medical treatment at an appropriate medical facility in case of illness or injury.
- Stating that you are aware of and accept the risk inherent in the program activity.
- Agreeing to hold harmless and indemnify the Board of Regents of the University of Wisconsin System, and the University of Wisconsin-Stout, their officers, agents and employees, from any and all liability, loss, damages, costs or expenses which are sustained, incurred, or required arising out of the actions of your dependent in the course of the camp/event.

Signature: ____________________ **Date:** ____________________
Parent/Guardian

UW-Stout Photo Consent

I understand that the university may take photographs of camp participants and activities. I agree that the University of Wisconsin-Stout shall be the owner of and may use such photographs relating to the promotion of future camps and in any University Publication. I relinquish all rights that I may claim in relation to the use of said photographs.

Signature: ____________________ **Date:** ____________________
Parent/Guardian