



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: _____

Date of Birth: Last First MI
M / D / Y Age Sex: Female Male

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
Foods Insect Bites/Stings
Medications (type) (EPI Pen - Required Yes No)

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 or Limitations? Explain.

Medical Treatment and Medication Administration Consent Form

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Participant: _____

Parent/Guardian: _____

Home Telephone: (____) _____ - _____ Work Telephone: (____) _____ - _____

Cellular 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, with the exception that controlled drugs (i.e. Codeine, Ritalin, Adderall, Dexadrine, etc.) must be by law administered by camp health staff.

All medications must be in original container and labeled with the camper's name, doctor's name and phone number, medication name, date prescribed and instructions.

- No** medication brought to camp.
- Yes**, prescription medication(s) and/or medical device(s) are brought to camp. *Complete medication box below.*
- Yes**, non-prescription/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:

- 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:

- I attest that all information on this form is correct.
- Acknowledging that you have received the notice of privacy practices statement.
- 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