



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: M/D/Y Sex: Female Male Height: Weight: MI

Home Address: \_\_\_\_\_

City: State: Zip: \_\_\_\_\_

Home Telephone Number: \_\_\_\_\_

Has participant had or is presently experiencing: (Please check all that apply)

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

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 Penicillin
Yes No Other Antibiotics
Yes No Other Medicine (type)
Yes No Insect Bites/Stings

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 and at least 4 weeks after first dose.

Tetanus-Diphtheria (initial series completed) M/D/Y

Year of last 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: \_\_\_\_\_

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-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:  
\_\_\_\_\_

- 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:**

- 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:** \_\_\_\_\_

# University of Wisconsin-Stout Student Health Services

## NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

As required by the privacy regulations created as a result of the health Insurance Portability and Accountability Act of 1996 (HIPAA). The Privacy Rules are lengthy and complex. This notice cannot cover the entire content of the Privacy Rules in every detail. If you would like a copy of the federal Privacy Rules, please go to <http://aspe.hhs.gov/admsimp/final/PvcTxt01.htm>

**This notice describes how health information about you may be used and disclosed and how you can get access to your individually identifiable health information.**

### PLEASE REVIEW THIS NOTICE CAREFULLY

UW-Stout Student Health Services is dedicated to maintaining the privacy of your individually identifiable health information (also called protected health information or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our operations. The Student Health Services uses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is the physical property of the University of Wisconsin-Stout Student Health Services.

We reserve the right to change the privacy practices described in this notice, in accordance with the law.

#### **How the Student Health Services May Use or Disclose Your Health Information (PHI):**

**For Treatment:** The Student Health Services may use your PHI to provide you with medical treatment or services. For example, information obtained by a health care provider, such as a physician, nurse, or other persons providing health services to you, will be recorded in your record. Your PHI is necessary for the health care providers to treat you or assist you. Health care providers will record actions taken by them in the course of your treatment and note how you respond to the actions. Your PHI may be shared between people who work at the Student Health Services, including, but not limited to our doctor and nurse, in order to treat you or to assist others in your treatment. Additionally, your PHI may be shared with other health care providers for purposes related to your treatment. Finally, your PHI may be shared with others who may assist in your care, such as your spouse, children or parent.

**For Payment:** The Student Health Services may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your

treatment to determine if your insurer will cover or pay for our treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

**For Health Care Operations:** The Student Health Services may use and disclose your PHI for operational purposes. For example, your PHI may be disclosed to members of the medical staff, students in health care professions, risk or quality improvement personnel, and others to evaluate the performance of our staff; assess the quality of care and outcomes in your case and similar cases; learn how to improve our facilities and services; determine how to continually improve the quality and effectiveness of the health care we provide; to provide quality learning experiences for undergraduate and graduate students in health care professions.

**Appointments, Treatment Options, Health Related Benefits and Services:** The Student Health Services may use your PHI to provide appointment reminders, or information about treatment alternatives, or other health-related benefits and services that may be of interest to the individual.

**Disclosures required by law and for law enforcement:** The Student Health Services may use/disclose your PHI when we are required to do so by federal, state or local law. Examples: for judicial and administrative proceedings pursuant to legal authority; to report information related to victims of abuse, neglect or domestic violence; to assist law enforcement officials in their law enforcement duties.

**Public Health:** Your PHI may be used/disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury or disability, or for other health oversight activities.

**Health Oversight Activities:** We may use/disclose your PHI to authorities for audits, investigations, inspections, licensure or other purposes related to oversight of the Student Health Services.

**Deceased Patients:** We may release PHI to a medical examiner/coroner and funeral directors to enable them to carry out their lawful duties.

**Research:** The Student Health Services may use/disclose your PHI for research purposes when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved the research.

**Health and Safety:** Your PHI may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

**For military, national security, or incarceration/law enforcement custody:** If you are involved with the military, national security or intelligence activities, or you are in the custody of law enforcement officials or an inmate in a correctional institution, we may disclose your health information to the proper authorities so they may carry out their duties under the law.

**Worker's Compensation:** Your PHI may be used/disclosed in order to comply with laws and regulations related to Worker's Compensation.

**Marketing:** We may contact you to give you information about health-related benefits and services that may be of interest to you.

**Academics:** Physicals, immunization records and the results of TB skin tests may be released to academic departments, affiliated clinical sites and work sites that require these records for academic programs or for employment.

**NOTE: Except for the situations listed above, we must obtain your specific written authorization for any other release of your health information.**

### **Your Rights Regarding your PHI:**

You have the following rights regarding the PHI that we maintain about you.

**Confidential Communication:** You have the right to receive confidential communication of health information. You may request that we communicate with you about your health and related issues in a particular manner. For example, you may wish to receive information about your health status in a special, private room or through a written letter sent to a private address. We will accommodate reasonable requests.

**Request restrictions on certain uses and disclosures.** You have the right to ask for restrictions on how your health information is used or to whom your information is disclosed, even if the restriction affects your treatment or

our payment or health care operation activities. However we are not required to agree to a requested restriction. In order to request a restriction in our use/disclosure of your PHI you must make your request in writing to UW-Stout Student Health Services 103 1<sup>st</sup> Avenue West, Menomonie, WI 54751

**Inspection and copies:** You have the right to inspect and receive a copy of your health information. This right does not apply to psychotherapy notes or information gathered for judicial proceedings. You must submit your request in writing to UW-Stout Student Health Services 103 1<sup>st</sup> Avenue West, Menomonie, WI 54751 in order to inspect and/or obtain a copy of your health information. In addition, we may charge you a reasonable fee if you want a copy of your health information.

**Amendment:** Request to correct your health information. If you believe your health information is incorrect, you may ask us to correct the information. To request an amendment, your request must be made in writing and submitted to UW-Stout Student Health Services 103 1<sup>st</sup> Avenue West Menomonie, WI 54751. You may be asked to make such requests in writing and to give a reason as to why your health information should be changed. However, if we disagree with you and believe your health information is correct, we may deny your request.

**Accounting of disclosures:** Receive a record of disclosures of your health information. An "accounting of disclosures" is a list of certain non-routine disclosures that we have made of your PHI for the purposes not related to treatment, payment or operations. In order to obtain an accounting of disclosures, you must submit your request in writing to UW-Stout Health Services 103 1<sup>st</sup> Avenue West Menomonie, WI 54751.

**Right to provide an authorization for other uses and disclosures:** We will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

**Paper Copy of this notice:** Receive a paper copy of this Notice of Privacy Practices upon request. You may also obtain a copy of this notice at our website: [www.uwstout.edu/studenthealth](http://www.uwstout.edu/studenthealth)

**File a complaint:** If you believe your privacy rights have been violated, you may file a written complaint with us or the secretary of the department of Health and Human Services. You will not be penalized for filing a complaint.

**If you have questions about this Notice, please contact the director or designee, UW-Stout Student Health Services 103 1<sup>st</sup> Avenue West Menomonie, WI 54751, 715/232-2114.**