

**CrossWoods Health History Form
For Campers & Adults**

Bring when you register: ✓ **This Completed Form**
 ✓ **Copy of Insurance Card** ✓ **Any medications in labeled containers**

2010

Camper Name _____ Birth Date ____/____/____ Age at Camp _____

Home Mailing Address _____
Street City State ZIP

| <i>Custodial parent/guardian</i> | <i>Second parent/guardian or other contact</i> | <i>If neither available, in an emergency notify</i> |
|----------------------------------|--|---|
| <small>Name</small> | <small>Name</small> | <small>Name</small> |
| Home Phone (____) _____ | Home Phone (____) _____ | Home Phone (____) _____ |
| Work Phone (____) _____ | Work Phone (____) _____ | Work Phone (____) _____ |
| Cell Phone (____) _____ | Cell Phone (____) _____ | Cell Phone (____) _____ |

Insurance Information

Is this camper covered by medical/hospital/health insurance? Yes No

If yes, please attach a photocopy of the front and back of the insurance card. And provide the following:

Insurance Carrier _____ Phone (____) _____

Group/Policy Number _____ Name of insured _____

Health History – A parent, legal guardian, physician or nurse practitioner may complete this section.

Physician's Name _____ Phone (____) _____

This individual is under the care of a physician for the following: _____

Provide month and year Tetanus booster _____ Hepatitis B _____ Polio _____
 for each immunization. Haemophilus b (HIB) _____ MMR _____ Varicella (Chicken Pox) _____

This individual has had chicken pox? Yes No This individual has had mononucleosis in the past 12 months? Yes No

This individual has a history of illness, injury or surgery that will affect participation? Yes No

If yes, explain: _____

Allergies - List all known
 Medication allergies

Describe reaction and management of the reaction:

Food allergies

Other allergies –include insect stings, hay fever, asthma, animal dander, etc...

DIET: No red meat No pork No eggs No poultry
 No seafood No dairy products Other _____

Name _____

(Over)

Medications: List **All** medications (*include over the counter/nonprescription*) taken routinely. Bring enough medication for entire camp in original bottle/packaging that identifies prescribing physician (*if prescription*), name of medication, dosage, and frequency. Medications dispensed according to label instructions. If the camper is not taking medication as indicated on the label, get the medication into a container properly labeled by a physician or pharmacist for current dosage. Campers are not allowed to self-medicate, except by necessity (*i.e. inhalers and the like*).

This person takes **NO** medications on a regular basis. This person **takes** medications on a regular basis (*include over the counter medications*)

Medication Name _____ Dosage _____ Taken daily Yes No

Reason taking _____ Date started _____

Medication Name _____ Dosage _____ Taken daily Yes No

Reason taking _____ Date started _____

Medication Name _____ Dosage _____ Taken daily Yes No

Reason taking _____ Date started _____

Medication Name _____ Dosage _____ Taken daily Yes No

Reason taking _____ Date started _____

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

Ongoing Health Concerns: Check all that pertain to this individual, and provide information about supportive healthcare.

- This individual has no ongoing health concerns
- This individual has the following ongoing health concerns
 - Asthma Headaches Sleepwalking Diabetes Frequent ear infections
 - Bedwetting Pregnancy Menstrual cramps or related concerns Other _____

Provide information about supportive health care for each checked item _____

If your child receives care/ medication for emotional, learning and/or psychological concerns, provide background information to help us work with this camper _____

Person completing this form _____ Date _____

Parent Initials

_____ I authorize an adult, in whose care the minor has been entrusted, to consent to X-ray examination, anesthetic, medical, surgical or dental diagnosis and treatment or hospital care for the above named minor. Such care is to be rendered under the general or specific supervision and on the advice of any physician or dentist licensed under the provisions of the Medical Practice Statutes of the State of Wisconsin, if there is insufficient time or inability to contact me. I will be liable and agree to pay all costs and expenses incurred in connection with such medical and dental services rendered pursuant to this authorization.

_____ I give permission for this minor to ride in any vehicle designated by the adult in whose care the minor has been entrusted.

_____ I will take no civil action against CrossWoods, Inc., any associated agencies, or persons in whose care the minor has been entrusted, for normal care of the minor in their charge.

_____ I give permission for this minor to receive non-prescription medications for non-emergency situations from a designated health-care provider.

_____ If my child has a headache, I usually give them _____ (*example: Tylenol, Ibuprofen, etc...*)

Signature of Parent / Legal Guardian _____ Date _____

FOR CAMP USE ONLY --- DO NOT WRITE BELOW THIS LINE

CrossWoods Check-In Nursing Notes

Nurse's Log Entries

Screening performed by _____ Date _____