CAMPER HEALTH HISTORY

Return this completed & signed form to:

(Before May 31st)
WeHaKee Camp for Girls
Administrative Office
715 28th Street, South
La Crosse, WI 54601 USA
FAX 608-787-8257

(After May 31st)
WeHaKee Camp for Girls
N8104 Barker Lake Road
Winter, WI 54896 USA
FAX 715-266-2267

Dates camper will attend camp: from_______________________ to ________________________
Month/Day/Year Month/Day/Year

Camper Name: ____
First Middle Last

☐ Female ☐ Male Birth date:______________________ Age at arrival at camp:________
Month/Day/Year

To Parent(s)/Guardian(s): *Please follow the instructions below. Attached additional information if needed.*

1. *Complete pages 1, 2, and 3 of this form and make a copy*
2. *Send the original, signed form to WeHaKee Camp for Girls by May 1st*
3. *If your daughter has significant health issues that will directly impact her experience at camp, please contact the Directors at WeHaKee Camp for Girls.*

Camper Home Address: ____
Street Address City/State (Province)/ Code Country

Parent/Guardian with legal custody to be contacted in case of illness or injury:

Name: ______________________________ Relationship to camper: ____________ Preferred Phones (___) ______________ (___) ______________
Email: ____

Home Address: ____
(if different than above) Street Address City/State (Province)/ Code Country

Second parent/guardian or other emergency contact:

Name: ______________________________ Relationship to camper: ____________ Preferred Phones (___) ______________ (___) ______________
Email: ____

Home Address: ____
(if different than above) Street Address City/State (Province)/ Code Country

Additional contact in event parent(s)/guardian(s) cannot be reached:

Name: ______________________________ Relationship to camper: ____________ Preferred Phones (___) ______________ (___) ______________

Allergies: ☐ No known allergies ☐ This camper is allergic to: ☐ Food ☐ Medicine ☐ The environment (insect stings, hay fever, etc.) ☐ Other

(Please describe below what the camper is allergic to and the reaction seen)

Diet Nutrition: ☐ This camper eats a regular diet ☐ This camper eats a regular vegetarian diet
☐ This camper has special food needs. ***(Please describe below.)***

Restrictions: ☐ I have reviewed the program and activities of WeHaKee Camp for Girls and feel the camper can participate without restrictions.
☐ I have reviewed the program and activities of WeHaKee Camp for Girls and feel the camper can participate with the following restrictions or adaptations. ***(Please describe below.)***

Medical Insurance Information:

This camper is covered by family medical/hospital insurance ☐ Yes ☐ No

Include a copy of your insurance card; copy both sides of the card so information is readable

Insurance Company ______________________________ Policy Number ____________________ Insurance Company Phone (___) ____________

Subscriber ______________________________ Subscriber Soc. Sec. Number ____________________ Subscriber Birth date __________________
Month/Day/Year

Parent/Guardian Authorization for Health Care:

This health history is correct and accurately reflects the health status of the camper to whom it pertains. I attest that all of my child's immunizations required for school are up to date (unless clearly noted in the Immunization History of this form). The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, WeHaKee Camp for Girls has my permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Custodial Parent/Guardian: ________________________________ Date: ____________ Relationship to Camper: ____________

If for religious or other reasons you cannot sign this, contact WeHaKee Camp for Girls for a legal waiver that must be signed for attendance.

CAMPER HEALTH HISTORY

Camper Name: ____
First Middle Last

Birth date: ______________________
Month/Day/Year

Immunization History: Provide the month and year for each immunization. Starred (★) immunizations must be current. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

Immunization		Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diphtheria, tetanus, pertussis★ (DTaP) or (TdaP)							
Tetanus booster ★ (dT) or TdaP)							
Mumps, measles, rubella ★ (MMR)							
Polio ★ (IPV)							
Haemophilus influenza type B (HIB)							
Pneumococcal (PCV)							
Hepatitis B							
Hepatitis A							
Varicella (chicken pox)	☐ Had chicken pox Date:						
Meningococcal meningitis (MCV4)							

Tuberculosis (TB) test Date: ____________ ☐ Negative ☐ Positive

If your camper has not been fully immunized, please sign the following statement: **I understand and accept the risks to my child from not being fully immunized.**

Signature of Custodial Parent/Guardian: ____ Date: ____________ Relationship to Camper: ______________

Medication: ☐ This camper will not take any daily medication while attending WeHaKee Camp for Girls

☐ This camper will take the following medication(s) while attending WeHaKee Camp for Girls:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. ***ALL PRESCRIPTION MEDICATIONS MUST BE IN ORIGINAL PHARMACY CONTAINER WITH LABELS which shows the camper's name and how the medication should be given. Provide enough of each medication to last the entire time the camper will be at camp. Please do not send non-prescription medications with your child unless they are needed on a daily basis. If you send non-prescription medication with your child, IT MUST BE IN ITS ORIGINAL CONTAINER WITH LABELS.***

- **All medication *(prescription and non-prescription, including vitamins and natural remedies)* MUST BE TURNED INTO THE HEALTH DIRECTOR UPON ARRIVAL AT WEHAKEE CAMP FOR GIRLS. This includes vitamins & natural remedies.**

Name of Medication	Date started	Reason for taking it	When it is given	Amount or dose given	How it is given
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:		

The following non-prescription medications may be stocked in the Health Center (BandAid) and are used on an as needed basis (PRN) to manage illness and injury. **PLEASE CROSS OUT THOSE THE CAMPER SHOULD NOT BE GIVEN.**

- Acetaminophen (Tylenol)
- Phenylephrine decongestant (Sudefed PE)
- Antihistamine/allergy medicine
- Diphenhydramine antihistamine/allergy medicine (Benadryl)
- Sore throat spray
- Lice shampoo or cream (Nix or Elimite)
- Calamine lotion
- Laxatives for constipation (Ex-Lax)
- Ibuprofen (Advil, Motrin)
- Pseudoephedrine decongestant (Sudafed)
- Guaifenesin cough syrup (Robitussin)
- Dextromethorphan cough syrup (Robitussin DM)
- Generic cough drops
- Antibiotic cream
- Aloe
- Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)

CAMPER HEALTH HISTORY

Camper Name: ____
First Middle Last

Birth date:______________________
Month/Day/Year

General Health History: ***Check "Yes" or "No" for each statement. Explain "Yes" answers below.***

Has/Does the camper:

1. Ever been hospitalized? ☐ Yes ☐ No
2. Ever had surgery? ☐ Yes ☐ No
3. Have a recurrent/chronic illness? ☐ Yes ☐ No
4. Have the capability for self-management of illness/condition including asking for assistance when necessary? ☐ Yes ☐ No
5. Had a recent infectious disease? ☐ Yes ☐ No
6. Had a recent injury? ☐ Yes ☐ No
7. Had asthma/wheezing/shortness of breath? ☐ Yes ☐ No
8. Have diabetes? ☐ Yes ☐ No
9. Had seizures? ☐ Yes ☐ No
10. Had headaches ☐ Yes ☐ No
11. Wear glasses, contacts, protective eyewear? ☐ Yes ☐ No
12. Had fainting or dizziness? ☐ Yes ☐ No
13. Passed out/had chest pain during exercise? ☐ Yes ☐ No
14. Had mononucleosis (mono) during past 12 months? ☐ Yes ☐ No
15. Have problems with periods/menstruation? ☐ Yes ☐ No
16. Have problems with falling asleep/sleepwalking? ☐ Yes ☐ No
17. Ever had back/joint problems? ☐ Yes ☐ No
18. Have a history of bedwetting? ☐ Yes ☐ No
19. Have problems with diarrhea/constipation? ☐ Yes ☐ No
20. Have any skin problems? ☐ Yes ☐ No
21. Traveled outside of USA in the past 9 months? ☐ Yes ☐ No

Please explain "Yes" answers in the space below, *noting the number of each "Yes" response.*
For travel outside of the USA, please name countries visited and dates of travel.

Mental, Emotional and Social Health: ***Check "Yes" or "No" for each statement. Explain "Yes" answers below.***

Has/Does the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? ☐ Yes ☐ No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder? ☐ Yes ☐ No
3. Have a diagnosis of a psychological disorder such as depression, panic/anxiety/OCD? ☐ Yes ☐ No
4. During the past 12 months, seen a professional to address mental/emotional health concerns? ☐ Yes ☐ No
5. Had a significant life event that continues to affect the camper's life? ☐ Yes ☐ No
   (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)
6. Does NOT possess personal appropriate hygiene abilities *(bathe, brush teeth, etc. when appropriate)*? ☐ Yes ☐ No
7. Does NOT possess the ability to interact effectively in a small group setting? ☐ Yes ☐ No

Please explain "Yes" answers in the space below, *noting the number of each "Yes" response. You may be contacted for additional information.*

Health-Care Providers: ***Please list the camper's health-care providers below***

Name of primary care doctor(s): ________________________ Clinic: ______________ Phone: (____) __________

Name of dentist(s): ________________________ Clinic: ______________ Phone: (____) __________

Name of orthodontist(s): ________________________ Clinic: ______________ Phone: (____) __________

Other health-care provider(s): ________________________ Clinic: ______________ Phone: (____) __________

What Have We Forgotten to Ask? ***Please provide any additional information*** *about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program.* ***Attach additional information if needed.***

This form is only considered completed if all three (3) pages are submitted together. Please keep a copy for your records.