

MINOR 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 participant will attend camp: from _____ to _____
Month/Day/Year Month/Day/Year

Participant 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
3. If your child has significant health issues that will directly impact her/his experience at camp, please contact the Directors at WeHaKee Camp for Girls.

Participant 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 participant: _____ 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 participant: _____ 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 participant: _____ Preferred Phones (____) (____) _____

Allergies: No known allergies This participant is allergic to: Food Medicine The environment (insect stings, hay fever, etc.) Other
(Please describe below what the participant is allergic to and the reaction seen)

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

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

Medical Insurance Information:

This participant 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 participant 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 Participant: _____

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

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Participant 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)	<input type="checkbox"/> Had chicken pox Date: _____					
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test Date: _____ Negative Positive

If the participant 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 Participant: _____

Medication: This participant will not take any daily medication while attending WeHaKee Camp

This participant will take the following medication(s) while attending WeHaKee Camp:

"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 participant's name and how the medication should be given. Provide enough of each medication to last the entire time the participant 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.**

Name of Medication	Date started	Reason for taking it	When it is given	Amount or dose given	How it is given
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> 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 PARTICIPANT SHOULD NOT BE GIVEN.**

- | | |
|--|---|
| <ul style="list-style-type: none"> • Acetaminophen (Tylenol) • Phenylephrine decongestant (Sudafed 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) | <ul style="list-style-type: none"> • 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) |
|--|---|

MINOR HEALTH HISTORY



Participant 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 participant:

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

- | |
|--|
| 1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Ever been treated for emotional or behavioral difficulties or an eating disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have a diagnosis of a psychological disorder such as depression, panic/anxiety/OCD? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. During the past 12 months, seen a professional to address mental/emotional health concerns? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Had a significant life event that continues to affect the participant's life? <input type="checkbox"/> Yes <input type="checkbox"/> No
<i>(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)</i> |
| 6. Possess personal appropriate hygiene abilities (bathe, brush teeth, etc. when appropriate)? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Possess the ability to interact effectively in a small group setting? <input type="checkbox"/> Yes <input type="checkbox"/> 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 participant'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 participant's health that you think important or that may affect the participant'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.