For Nearly 100 Years
WeHaKee
CAMP FOR GIRLS

Sept. 1st – May 31st
- Administrative Office -
715 28th Street, South
La Crosse, Wisconsin 54601 USA
1-800-582-2267 FAX 1-608-787-8257
Internationally: 001-608-787-8304

June 1st – August 31st
- WeHaKee Camp for Girls -
N8104 Barker Lake Road
Winter, Wisconsin 54896 USA
1-800-582-2267 FAX 1-715-266-2267
Internationally: 001-715-266-3263

Camper Health History

Please submit the completed form by May 1st to WeHaKee Camp for Girls Administrative Office. ***Parent(s)/Guardian(s): Please follow the instruction below. Attach additional information if needed.***

1. *Only* ***ONE CAMPER*** *per form.*
2. *Complete all pages. Make a copy to keep for your records.*
3. *Send the original, signed form to WeHaKee Camp for Girls by May 1st.*
4. *If your daughter has significant health issues that will directly impact her experience at camp, please contact the Directors at WeHaKee Camp for Girls.*

Camp Arrival Date: _____ Camper Name: *(First, Middle, & Last)* _____

☐ Female ☐ Male Birthdate: *(Month/Day/Year)* _____ Age: _____

Camper Information - *Please print clearly*

Camper Home Address: _____
Street *City/State (Province)/Zip (Postal) Code* *Country*

Parent/Guardian Information - *Please print clearly*

Parent/Guardian with Legal Custody to be Contacted in Case of Illness or Injury:

Name: _____ Relationship to Camper: _____

Preferred Phone *(1)*: _____ Preferred Phone *(2)*: _____

E-mail Address: _____

Home Address: _____
(If different than above) *Street* *City/State (Province)/Zip (Postal) Code* *Country*

Second Parent/Guardian or Other Emergency Contact:

Check this box if this person has current legal custody of the above named child: ☐

Name: _____ Relationship to Camper: _____

Preferred Phone *(1)*: _____ Preferred Phone *(2)*: _____

E-mail Address: _____

Home Address: _____
(If different than above) *Street* *City/State (Province)/Zip (Postal) Code* *Country*

Additional Contact in Event Parent(s)/Guardian(s) Cannot be Reached:

Name: _____ Relationship to Camper: _____

Preferred Phone *(1)*: _____ Preferred Phone *(2)*: _____

Allergies

☐ No known allergies ☐ 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

☐ Regular diet ☐ Regular vegetarian diet ☐ Vegan ☐ 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.)*

This form is only considered completed if all four (4) pages are submitted together. Please keep a copy for your records.

Camper Health History Continued

Camper Name: *(First, Middle, & Last)* _____

Birthdate: *(Month/Day/Year)* _____

Medical Insurance Information - *Include a copy of your insurance card; copy both sides of the card so information is readable.*

Camper is covered by family medical/hospital insurance: ☐ Yes ☐ No

Insurance Company: _____ Policy Number: _____ Insurance Company Phone: _____

Subscriber: _____ Subscriber Number: _____

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

Because our camp program has a potential for communicable diseases, we expect that program participants are appropriately immunized for, at minimum, the following diseases: tetanus, mumps, measles, rubella, polio, pertussis (whooping cough), meningitis, hepatitis B, varicella (chicken pox) and diphtheria. If this participant is not fully immunized per our expectation, please contact our Administrative Office prior to completing this Health History form.

Medication

"Medication" is any substance a person takes to maintain and/or improve their health—this includes vitamins & natural remedies. 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**.

Medication Information & Requirements is continued on page 3.

This form is only considered completed if all four (4) pages are submitted together. Please keep a copy for your records.

Camper Health History Continued

Camper Name: *(First, Middle, & Last)* _____

Birthdate: *(Month/Day/Year)* _____

Prescription Medication

All prescription medications must be in the 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.

☐ 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 Name	Date Started	Reason	When Given	Amount/Dose Given	How It Is Given
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:		

Non-Prescription Medication - *Including all over-the-counter medication.*

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 ALL LABELS ATTACHED**. 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.**

- Aloe
- Antibiotic cream
- Acetaminophen (Tylenol)
- Ibuprofen (Advil, Motrin)
- Generic cough drops
- Calamine lotion
- Sore throat spray
- Diphenhydramine antihistamine/allergy medicine (Benadryl)
- Stool softeners for constipation
- Lice shampoo or cream (Nix or Elimite)

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. LACK the capability for self-management of illness/condition including asking for assistance when necessary? ☐ Yes ☐ No
5. Had an infectious disease in past 12 months? ☐ Yes ☐ No
6. Had an injury in past 12 months? ☐ 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. Had a concussion(s)? ☐ Yes ☐ No
12. Wear glasses, contacts, protective eyewear? ☐ Yes ☐ No
13. Had fainting or dizziness? ☐ Yes ☐ No
14. Passed out/had chest pain during exercise? ☐ Yes ☐ No
15. Had mononucleosis (mono) during past 12 months? ☐ Yes ☐ No
16. Have problems with periods/menstruation? ☐ Yes ☐ No
17. Have problems with falling asleep/sleepwalking? ☐ Yes ☐ No
18. Ever had back/joint problems? ☐ Yes ☐ No
19. Have a history of bedwetting? ☐ Yes ☐ No
20. Have problems with diarrhea/constipation? ☐ Yes ☐ No
21. Have any skin problems? ☐ Yes ☐ No
22. Traveled outside of USA in the past 9 months? ☐ Yes ☐ No

Please explain ALL "Yes" answers in the space below, noting the number of each "Yes" response. Please include treatment plans or recommendations while at camp if applicable. For travel outside of the USA, please name countries visited and dates of travel.

This form is only considered completed if all four (4) pages are submitted together. Please keep a copy for your records.

Camper Health History Continued

Camper Name: *(First, Middle, & Last)* _____

Birthdate: *(Month/Day/Year)* _____

Mental, Emotional & 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. LACK personal appropriate hygiene abilities (bathe, brush teeth, etc. when appropriate)? ☐ Yes ☐ No
7. LACK the ability to interact effectively in a small group setting? ☐ Yes ☐ No

Please explain ALL "Yes" answers in the space below, noting the number of each "Yes" response. Please include treatment plans or recommendations while at camp if applicable. 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/Location: _____ Phone: _____

Name of dentist(s): _____ Clinic/Location: _____ Phone: _____

Name of orthodontist(s): _____ Clinic/Location: _____ Phone: _____

Other health-care provider(s): _____ Clinic/Location: _____ 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.

Parent/Guardian Authorization for Health Care

I confirm that I am the parent/legal guardian of the child listed on this Health History form and as such I have current legal custody of said child. 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: _____

This form is only considered completed if all four (4) pages are submitted together. Please keep a copy for your records.