For Over 100 Years
WeHaKee
CAMP FOR GIRLS

Sept. 1st – May 31st
- Administrative Office -
2318 6th Street, North
Sheboygan, Wisconsin 53083 USA
608-787-8304
Internationally: 001-608-787-8304

June 1st – August 31st
- WeHaKee Camp for Girls -
N8104 Barker Lake Road
Winter, Wisconsin 54896 USA
608-787-8304
Internationally: 001-608-787-8304

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 child has significant health issues that will directly impact their experience at camp, please contact the Directors at WeHaKee Camp for Girls.*

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

Sex Assigned At Birth: ☐ 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)*:_____

Medical Insurance Information

You are required to submit a copy of your health 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

This camper is currently vaccinated in accordance with the American Academy of Pediatrics' most recent Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger (including the following vaccinations for diphtheria, tetanus, pertussis, mumps, measles, rubella, COVID-19, PCV, Hepatitis B & A, Varicella/chicken pox, meningococcal meningitis). ☐ Yes ☐ No*

**If NO to any of these vaccinations, please contact our Administrative Office as soon as possible.*

Please provide **official documentation** of your child's immunization history. This documentation can be acquired from your family health-care provider of from your local or state government. This form is not complete and your child may not be admitted to camp without this official documentation.

Because our camp community has the potential for the presence of communicable diseases, all program participants are REQUIRED to be vaccinated in accordance with the American Academy of Pediatrics' most recent Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger (https://tinyurl.com/y7bkysdf). Only medical exemptions to our immunization requirement will be considered. Official written documentation signed by an appropriately licensed medical professional is required for exemption consideration.

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

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

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.)

Medication

"Medication" is any substance a person takes to maintain and/or improve their health – this includes vitamins, supplements, and homeopathics. All medication *(prescription and non-prescription, including vitamins, supplements, and homeopathics)* **must be turned into the health director upon arrival at WeHaKee Camp for Girls**.

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**.

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

Name of primary health-care provider: _____ Clinic/Location: _____ Phone: _____

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

Diet Nutrition

☐ Regular diet ☐ Regular vegetarian diet ☐ Vegan ☐ Camper has special food needs. *(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 Legal Name: *(First, Middle, & Last)* _____

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

Restrictions

☐ I have reviewed the program and activities of WeHaKee Camp for Girls and I confirm that the camper can participate without restrictions.

☐ I have reviewed the program and activities of WeHaKee Camp for Girls and I confirm that the camper can participate with the following restrictions or adaptations. *(Please describe below.)*

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

Has/Does the Camper:

1. Ever been hospitalized?	☐ Yes	☐ No	12. Had fainting or dizziness?	☐ Yes	☐ No
2. Ever had surgery?	☐ Yes	☐ No	13. Passed out/had chest pain during exercise?	☐ Yes	☐ No
3. Have a recurrent/chronic illness?	☐ Yes	☐ No	14. Had mononucleosis (mono) during past 12 months?	☐ Yes	☐ No
4. Had an infectious disease in past 12 months?	☐ Yes	☐ No	15. Have problems with periods/menstruation?	☐ Yes	☐ No
5. Had an injury in past 12 months?	☐ Yes	☐ No	16. Have problems with falling asleep/sleepwalking?	☐ Yes	☐ No
6. Had asthma/wheezing/shortness of breath?	☐ Yes	☐ No	17. Ever had back/joint problems?	☐ Yes	☐ No
7. Have diabetes?	☐ Yes	☐ No	18. Have a history of bedwetting?	☐ Yes	☐ No
8. Had seizures?	☐ Yes	☐ No	19. Have problems with diarrhea/constipation?	☐ Yes	☐ No
9. Had headaches?	☐ Yes	☐ No	20. Have any skin problems?	☐ Yes	☐ No
10. Had a concussion(s)?	☐ Yes	☐ No	21. Traveled outside of USA in the past 9 months?	☐ Yes	☐ No
11. Wear glasses, contacts, protective eyewear?	☐ 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. Also include a description of the camper's capability for self-management of the illness/condition including asking for assistance when necessary. 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 Legal 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? ☐ Yes ☐ No
3. Currently have an eating disorder or been treated for one in the past? ☐ Yes ☐ No
4. Experienced excessive anxiety or panic attacks? ☐ Yes ☐ No
5. Experienced symptoms consistent with depression, panic/anxiety/OCD? ☐ Yes ☐ No
6. Have a diagnosis of a psychological disorder such as depression, panic/anxiety/OCD? ☐ Yes ☐ No
7. Exhibit challenges in engaging or interacting with others? ☐ Yes ☐ No
8. Exhibit challenges in successfully managing their ability to live in community with others? ☐ Yes ☐ No
9. During the past 12 months, seen a professional to address mental/emotional health concerns? ☐ Yes ☐ No
10. Had a significant life event that continues to affect the camper's life? *(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)* ☐ Yes ☐ No
11. LACK personal appropriate hygiene abilities (bathe, brush teeth, etc. when appropriate)? ☐ Yes ☐ No
12. LACK the ability to interact effectively in a small group setting? ☐ Yes ☐ No
13. Had/Have any significant issues during their lifetime that has resulted in her experiencing any mental, emotional, social or other distress? ☐ Yes ☐ No

Please explain ALL "Yes" answers in the space below, noting the number of each "Yes" response. Include a specific description of related behaviors, how the behaviors or issues are managed at school and home, and any other pertinent information that will help us better care for your child while at camp. Please include treatment plans or recommendations while at camp if applicable. You may be contacted for additional information.

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

As needed, we will call this child's health-care provider directly to clarify treatment plans and other related care. Check the box below if you prefer we do not make direct contact with the child's health-care provider.

☐ Please do not contact the health provider prior to contacting us (parent/guardian).

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 complete and thorough and accurately reflects the health status of the camper to whom it pertains. I attest that all of my child's immunizations are up to date in accordance with the American Academy of Pediatrics' most recent Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger. 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. In the event that my child is hospitalized for an extended period (more than 1 night), I understand that I am responsible for making immediate arrangements to travel to their hospital location to provide supervision, personal support, transportation, etc. I understand the information on this form may 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.