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

Health-Care Provider Recommendation Form

Please submit the completed form by May 1st to WeHaKee Camp for Girls Administrative Office.
Parent(s)/Guardian(s): Please complete Section A of this form, then give this form to your child's health-care provider for review and signature.

Section A: Camper and Parent(s)/Guardian(s) Information

Dates Camper Will Attend Camp WeHaKee: From _____ to _____
Month/Day/Year *Month/Day/Year*

Camper Legal Name: _____
First *Middle* *Last*

Sex Assigned At Birth: ☐ Female ☐ Male Birthdate: _____ Age On Arrival At Camp: _____
Month/Day/Year

Camper Home Address: _____
Street

_____
City *State (Province)* *Country* *Postal Code*

Custodial Parent(s)/Guardian(s) Phone Number(s): (_____) _____ (_____) _____

PARENT(S)/GUARDIAN(S) stop here. Rest of form (SECTION B) to be completed by licensed health-care provider.

Section B

To be completed & signed by a licensed health-care provider.

This camper is undergoing treatment at this time for the following conditions: ☐ None at this time ☐ Yes
(Please describe below.)

Medication: ☐ No daily medications
☐ Will take the following prescribed medication(s) while at camp: *(Medication name, dose, frequency – describe below.)*

Other treatments/therapies to be continued at camp: ☐ None at this time ☐ Yes
(Please describe below.)

Do you feel that the camper will require limitations or restrictions to activity while at camp? ☐ No ☐ Yes
If 'Yes', what do you recommend? (Please describe below – attach additional information if needed.)

I have reviewed this camper's health history and have discussed the camp program with the camper's parent(s)/guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above).

Signature: _____ Date: _____

Name of licensed provider *(please print)*: _____ Title: _____

Office Address: _____
Street *City* *State (Province)* *Country* *Postal Code*

Telephone: (_____) _____ Date: _____