Wisconsin 4-H Camp Health Form



Event Name:

Dates:

PARTICIPANT'S PERSON		MATION (please print)					
FIRST NAME:	MIDDLE IN	IT.: LAST N	NAME:	BIRTHDATE (Mo/I	Day/Yr.): SEX		PRIMAR	Y PHONE NUMBER:
MAILING ADDRESS STREET:					CITY:		STATE:	ZIP:
MALING ADDRESS STREET.					CITT.		STATE.	ZIF.
NAME OF PRIMARY PARENT/LEG	AL CUSTOD	IAN IN CASE	OF ILLNESS OR INJURY:		WORK TELE	PHONE NUMBER:	CELL PHO	ONE NUMBER:
NAME OF SECOND PARENT/LEG	AL CUSTODI.	AN IN CASE	OF ILLNESS OR INJURY:		WORK TELE	PHONE NUMBER:	CELL PHO	ONE NUMBER:
PARTICIPANT'S HEALTH		OVIDER IN	IFORMATION					
HEALTH CARE PROVIDER NAME:								
MEDICAL FACILITY NAME:				TELEPHONE NUM	IBER:			
☐ This participant has no kr	nown aller	gies.		•				
☐ This participant is allergic	to this for	od(s):		Does this a	llergy cause	e anaphylaxis?]Yes [] No
This participant is lactose	intolerant	t.		☐ This partici	pant is glute	en intolerant.		
Other (please explain):								
This participant is allergic	to medica	ation(s):	Environment	(insect stings, h	ay fever, et	c)		
Please describe below what	this partic	ipant is alle	ergic to and the reaction	on seen:				
MEDICATION								
☐ This participant will NOT	take any n	nedications	s while attending camp	o (over the coun	ter or presc	ribed).		
This participant will take t is in the original container lal of the form.)								
	Amount or Dose	_					Guardian	cy Medication Only Legal to initial below if camper e to carry and self-
Name of Medication	Given	Reason for	Taking It	When It Is Give	n	How It Is Given	adminis	ter (i.e inhaler, epi-pen)
				Lunch Dinner Bedtime Other time:				
				Breakfast Lunch Dinner Bedtime Other time:		_		
-				Breakfast Lunch Dinner Bedtime Other time:				
				☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:				



This participant does NOT have asthma. This participant does have asthma. Asthma Triggers Signs/Symptoms of asthma episode Frequency of episodes How episode is managed Exercise Colds Image: Signs/Symptoms How episode is managed Allergies (to what?) Weather (what type?) Image: Signs/Symptome astrong Signs/Symptoms Other (list) Image: Signs/Symptome astrong How episode is managed Signs/Symptoms Image: Signs/Symptoms Image: Signs/Symptoms Image: Signs/Symptoms Signs/Symptoms Other (list) Image: Signs/Symptoms Image: Signs/Symptoms Signs/Symptoms Image: Signs/Symptoms Image: Signs/Symptoms Image: Signs/Symptoms Signs/Symptoms Image: Signs/Symptoms Image: Signs/Symptoms Signs/Symptoms Signs/Symptoms Image: Signs/Symptoms Image: Signs/Symptoms Image: Signs/Symptoms Signs/Symptoms Image: Signs/Symptoms Image: Signs/Symptoms Image: Signs/Symptoms Signs/Symptoms Image: Signs/Symptoms Image: Signs/Symptoms Image: Signs/Symptoms Signs/Symptoms Image: Signs/Symptoms Image: Signs/Symptoms Signs/Symptoms Signs/Sympto			Breal Lunc Dinn Bedt Othe	ch er ime				
Insurance Company: Policy Number: Subscribe: Insurance Company Phone Number: ASTHMA This participant does NOT have asthma. This participant does NOT have asthma. This participant does have asthma. Asthma Triggers Signs/Symptoms (check all that apply) of asthma episode Frequency of episodes How episode is managed [] Infections Exercise Colds	MEDICAL INSURANCE INFORMA	TION:						
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SIGNATURE	PLEASE INDICATE ANY OTHER I	MPORTANT MEDICAL C		o be given; mental,	emotional, or so	cial health)		

This health history is correct and accurately reflects the health status of the participant. The person described has permission to participate in all event activities except as noted by me or an examining physician. I give permission to the event to provide routine healthcare services, administer medications, and seek emergency services.

SIGNATURE - Parent/Guardian/Legal Custodian

DATE



CONSENT FOR MEDICATION ADMINISTRATION AND MEDICAL TREATMENT

TO THE PARENT(S) OR LEGAL GUARDIAN:

If your son, daughter, or ward will be under the age of 18 while participating in a University of Wisconsin – Madison Division of Extension event/camp/program, it is event/camp/program policy to secure your consent for medication distribution and for the use of medical devices. The medication or medical device must be administered by designated event/camp/program health staff with the exception that a limited amount of medication for life-threatening conditions may be carried and administered by my son/daughter/ward (i.e. bee sting kit, inhaler, insulin syringe).

It is event/camp policy to secure your consent for medication distribution and for the use of medical devices by signing below.

Please check all that apply:

Yes	No		
		Medication(s) has been brought to event/camp.	
		Prescription medication(s) has been brought to event/camp. All prescription medication must be in the original medicine bottle and labeled with the youth participant's name, doctor's name, medication name, dosage, prescription number, date prescribed, and instructions. Also, information about any prescription medications must be provided in writing to event/camp health staff with the information requested in the later section of this form.	Sizicoline
		Over-the-counter medications have been brought to event/camp and may be administered by event/camp health staff as needed. All over-the-counter medications must be labeled with the youth participant's name, medication name, dosage and instruction.	

If your son, daughter, or ward will be under the age of 18 years while at the event/camp, it is our policy to secure your consent for **all of the following**. By signing below,

- I am giving my consent in advance for medical treatment at an appropriate medical facility in case of illness or injury.
- I am stating that I am aware of and accept the risk inherent in the program activity.
- I attest that all information on this form is correct and up-to-date, and that I will provide any and all significant material, and important changes to any information in this form to event/camp staff no later than check-in.

Participant Name (Please Print)

SIGNATURE OF PARENT OR LEGAL GUARDIAN

Date

This is the approved health form for 4-H events and camps.

