Timbertop Camp Health History Form

FULLY COMPLETE ALL SECTIONS of this YEARLY REQUIRED Health and Care Form and return to:
info@timbertopcamp.org or by mail to: P.O. Box 423, Plover, WI 54467 (715) 869-6262

Participant Name ________________________ Birth Date __________ Age ______ ❑ M ❑ F

Street Address ____
Street City State Zip

Home Phone ________________ School ________________ Grade______ Height ______ Weight______

Parent/Guardian Name ______________________
Home Address ______________________
City ____________ State _______ Zip _______
Workplace & Ph. # ______________________
Day/Cell Ph.____________ Home Ph. ____________
Email ______________________

Parent/Guardian Name______________________
Home Address ______________________
City ____________ State _______ Zip ______
Workplace & Ph. # ______________________
Day/Cell Ph.____________ Home Ph. ____________
Email ______________________

Please Indicate any Custody Issues ____

Emergency Contacts (other than Parent/Guardian) and Persons Authorized to Pick Up

Emergency Contact Name ______________________
Relationship to Participant ______________________
Day/Cell Ph.____________ Home Ph. ____________

Emergency Contact Name______________________
Relationship to Participant ______________________
Day/Cell Ph.____________ Home Ph. ____________

Participant's Physician ____________________________________ Phone ______________
Dr. Name/Facility Office Address

Participant's Dentist ____________________________________ Phone ______________
Dr. Name/Facility Office Address

Insurance Information: Is Participant covered by family medical/hospital insurance? ____ YES ____ NO

Carrier or Plan Name ______________________ Member ID# ______________ Group# ____________

Carrier Address & Phone # ____

Name of Insured & Birth Date ______________________ Relationship to Participant ________________

IMMUNIZATION HISTORY: Provide the month/year for each immunization. Starred (*) immunizations must be current.
Copies of immunization forms from health-care providers or state 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	Recent month/year
*Diptheria-Tetanus-Pertussis (DTP, DTaP, DT)						
*Tetanus Booster (dT) or (TdaP)						
*Measles-Mumps-Rubella (MMR)						
*Polio (IPV)						
Haemophilus Influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox)			❑ Had Chicken Pox **Date:**			
Meningococcal meningitis (MCV4)						
Tuberculosis (TB) Test Date:		❑ +pos	❑ -neg			

OVER

Participant Name ______________________________ **Birth Date** __________ **Age** ______ ❑ M ❑ F

HEALTH CONDITIONS: (Check any that apply to the participant and explain below, include severity.)

❑ Sleepwalking	❑ Frequent Ear Infections	❑ Skin Problems	❑ Cerebral Palsy/Motor
❑ Bed-wetting	❑ Heart Defect/Disease	❑ Joint/Bone Problems	❑ Picky Eater
❑ Athlete's Foot	❑ High Blood Pressure	❑ Head/Neck/Back Injuries	❑ Vegetarian
❑ Warts	❑ Diabetes	❑ Epilepsy/Convulsions/Seizures	❑ Allergies
❑ Eating Disorder	❑ Frequent Headaches	❑ Visual Impairment/Glasses…	❑ Asthma
❑ Diarrhea/Constipation	❑ Indigestion	❑ Hearing Impairment/Aids…	❑ Other ____________
❑ Abnormal Menstruation	❑ Sinus Trouble	❑ Speech Impairment	❑ Other ____________
❑ Homesickness	❑ Frequent Nose Bleeds	❑ Learning Disability	
❑ Doesn't Swim (describe)	❑ Bleeding Clotting Disorder	❑ ADD or ADHD	❑ Does participant have a School IEP?
❑ Nightmares	❑ Fainting/Dizziness	❑ Cognitive Disability	
❑ Exercise Induced Difficulties	❑ Emotional/Behavior Disorder	❑ Chronic Illness/Condition	

Give details including triggers, signs/symptoms, care procedures and when to call parent and/or 911 for any conditions checked above: ____

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ALLERGIES: List and Describe reaction/symptoms, management instructions and when to call parent or 911.

Medications: ____

Foods: ____

Insects, Animals, Plants …____

RESTRICTIONS or Other things we forgot to ask: List and describe any restrictions or limitations including: Recent injury/illness/infection, Dietary, Health Conditions (physical, behavioral, emotional, mental), Impairments, Other Illnesses, Major Surgeries, Special Needs and indicate if there are any adaptations that could be made: _________

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MEDICATIONS: All Medications/Vitamins are REQUIRED to be in original containers, be clearly labeled and include written instructions. Attach additional pages as needed.

	Medication Name	Dosage (tabs & mg)	Circle Time(s) to be Taken or write "PRN"(only as Needed)	Reason for Taking:
1.	______________	______	9am 1pm 4pm 7pm Bed other:____	________________
2.	______________	______	9am 1pm 4pm 7pm Bed other:____	________________
3.	______________	______	9am 1pm 4pm 7pm Bed other:____	________________
4.	______________	______	9am 1pm 4pm 7pm Bed other:____	________________
5.	______________	______	9am 1pm 4pm 7pm Bed other:____	________________

Special Instructions: ____

_____ **P/G Initials** I hereby give permission to Timbertop Camp Directors/Volunteers to give participant the medications (as directed) listed above and on any additional page. I also give permission to Timbertop Camp Directors/Volunteers to give the participant over-the-counter camp medications (as directed) in the event of minor pain/ailment (i.e. headache, stomach ache, sun protection, insect bites, etc…).

_____ **P/G Initials** I hereby state that the information I have provided is accurate and complete. I understand that it is my responsibility to provide any changes/updates to Timbertop Camp. I further understand that failure to provide accurate, complete, and updated information may jeopardize participation in this program. If participant has NOT been fully immunized – I understand and accept the risks from not being fully immunized.

_____ **P/G Initials** In the event that I or emergency contact listed cannot be reached in an emergency, I give my consent for Timbertop Camp Directors/Volunteers to act in my behalf in granting permission for participant to receive emergency treatment. I will be responsible for the payment of any and all medical services rendered. The camp has permission to obtain a copy of participant's health record from providers who treat participant and these providers may talk with the staff about participant's health status.

______________________________	______________________________	__________
Participant's Name - Please Print	Signature of Legal Parent/Guardian	Date