

TOWERING PINES/WOODLAND

Eagle River, WI 54521

Camper Health Form

NAME _____

SS# _____

Date of Birth _____ Age _____

Male Female

HEALTH HISTORY (must be updated within 6 months prior to camp season)

Parent _____ Cell Phone _____ Business _____

Home Address _____ Cell Phone _____

Summer Address _____ Phone _____

Parent: Please check the illnesses your son/daughter has had:

- | | | |
|---|--|--|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Diabetes | Allergies: <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> German Measles | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Bee Sting |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Skin Rashes |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Epilepsy or Convulsions | <input type="checkbox"/> Medication _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Food _____ |

Other illnesses, injuries, operations or past medical treatment: _____

Subject to: Ear-ache _____ Sore Throat/Strep _____ Nightmares _____ Sleep Walking _____
Bed Wetting _____ Motion Sickness _____ Infections _____ Other _____

(Female) Menstrual History: _____

Activity or diet restrictions: _____

Current medications; Prescription & over the counter (send with instructions):

Name	Health issue	Instructions
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Parent Suggestions: _____

I hereby authorize the Director or medical personnel selected by Towering Pines/Woodland Camps to act on my behalf in event of emergency and in all matters of health and welfare of my child. In the event that I cannot be reached, I hereby give permission to the physician selected by the camp to hospitalize and secure proper treatment for my child.

Date _____ Signature of Parent/Guardian _____

Health & Accident Insurance coverage provided by _____

Address _____ Policy # _____

Phone contact _____ Group # _____

Please attach copy of insurance card

STATEMENT OF PHYSICIAN (Please attach a copy of the patients health history)

Is this patient up to date on necessary immunizations? _____ List date of booster: **Tetanus** _____

Is the camper under any medical or dietary regime that should be continued at camp? _____

Does he/she have any physical or mental condition that our nurse or camp doctor should know? _____

Your recommendations or any restrictions: _____

Date of health exam : _____ (must be within the past 24 months)

On the basis of the examination on this day this child may participate in activities at summer camp.

Signature of Physician _____ Phone (_____) _____

Name/Address _____ Date Signed _____