TOWERING PINES/WOODLAND
Eagle River, WI 54521
Camper Health Form
Camp Insurance: ❑ Yes ❑ No

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 ______________________ Phone ____________

Summer Address ______________________ Phone ____________

Please check the illnesses your son/daughter has had:

❒ Measles
❒ German Measles
❒ Mumps
❒ Chicken Pox
❒ Asthma
❒ Diabetes
❒ Scarlet Fever
❒ Rheumatic Fever
❒ Epilepsy or Convulsions
❒ Bleeding Disorders

Allergies: ❒ Hay Fever
❒ Bee Sting
❒ Skin Rashes
❒ Medication ____________
❒ 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: ______________________
Policy Holder ______________________ Policy # ____________
Phone contact ______________________ Group # ____________
Please attach copy of the front and back of your insurance card

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STATEMENT OF PHYSICIAN

*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, mental or psychological condition that our nurse or camp doctor should know?

____

Your treatment 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 ____________

***Please attach a copy of the patients health history**

revised 4/11