



Health History Questionnaire
for Athletic Summer Camps/Programs

Completion of both sides of form is REQUIRED prior to participation (HFS 175)

CAMP EVENT: _____

CAMP DATES: _____

Participant: _____

Date of Birth: M / D / Y Sex: Female Male Height: Weight: MI

Home Address: _____

City: State: Zip: _____

Home Telephone Number: _____

Has participant had or is presently experiencing: (Please check all that apply)

- Yes No Allergies
Yes No Epilepsy/Seizures/Blackouts
Yes No Menstrual Difficulties
Yes No Asthma
Yes No Heart Disease
Yes No Mental/Emotional Problems
Yes No Bleeding Disorder
Yes No Hernia
Yes No Neck/Back Pain/Injury
Yes No Cancer
Yes No High Blood Pressure
Yes No Rheumatic Fever
Yes No Colitis
Yes No Joint Injury/Surgery
Yes No Tuberculosis
Yes No Diabetes
Yes No Kidney Disease
Yes No Ulcer

Does participant take medication on a regular basis? Yes No If yes, identify
(Consent for medication administration must be signed on reverse side)

Does participant have allergic reactions to:

- Yes No Penicillin
Yes No Other Antibiotics
Yes No Other Medicine (type)
Yes No Insect Bites/Stings

Immunization Record

MMR (measles, mumps, rubella)

* Dose 1 - given at age 12-15 months or later M / D / Y * Dose 2 - given at age 4-6 years or later M / D / Y and at least 4 weeks after first dose.

Tetanus-Diphtheria (initial series completed) M / D / Y

Year of last tetanus booster (Preferably within last 10 years) M / D / Y

Has participant ever had major surgery or been hospitalized? Yes No If yes, explain:

Please explain any significant operations, accidents or illnesses, and last medical attention and reason:

Does the participant have any physical condition(s) requiring special considerations? Explain.

A physical examination within 24 months of the camp/event is recommended. Date of participant's last physical examination:

Medical Treatment and Medication Administration Consent Form

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Participant: _____

Parent/Guardian: _____

Home Telephone: _____ Work Telephone: _____

Name of Physician: _____ Telephone: _____

Name of Insurance: _____ Policy #: _____

Alternative contact in the event that the Parent/Guardian cannot be contacted in the case of an emergency (injury/illness) involving the participant named above.

Name: _____ Relationship: _____ Telephone: _____

If your son, daughter or ward will be under the age of 18 years while at the University of Wisconsin-Stout, it is policy to secure your consent for medical treatment and medication distribution, whether medication/treatment is self-administered or administered by designated camp staff.

All medications must be in *original or separate medicine bottles and labeled with the camper's name*. Prescription medication(s) must also include on the label *doctor's name and phone number, medication name and dosage*.

- No** medication brought to camp.
- Yes**, non-prescription/over the counter medications are being brought to camp. Non-prescription/over the counter medication can be self-administered. Please indicate the name of the medication(s), dosage, and reason for taking the medication:

If camper is **NOT** allowed to self-administer non-prescription/over the counter medications, sign here:

- Yes**, prescription medication(s) and/or medical device(s) are brought to camp. *Complete medication box below.*
- Yes**, I will self-administer the medication(s) and/or medical device(s). ***This is allowed if 14 years old or older.***
- Designated camp staff, i.e. nurse, athletic trainer, camp counselor, will administer the medication(s) and/or medical device(s). ***Mandatory for age 13 and under.***
*** However, a limited amount of medication for life threatening conditions may be carried by my son/daughter/ward, i.e. allergy medications, bee sting kits, inhalers, insulin.*

Name of Medication and prescribing MD	Dosage	How is it taken, i.e. oral, injection	Time(s) of day medication is taken	Day(s)/Number of days medication is to be taken

Special Instructions: _____

By signing below, you are:

- Acknowledging that you have received the notice of Privacy Practices statement.
- Giving your consent in advance for medical treatment at an appropriate medical facility in case of illness or injury.
- Stating that you are aware of and accept the risk inherent in the program activity.
- Agreeing to hold harmless and indemnify the Board of Regents of the University of Wisconsin System, and the University of Wisconsin-Stout, their officers, agents and employees, from any and all liability, loss, damages, costs or expenses which are sustained, incurred, or required arising out of the actions of your dependent in the course of the camp/event.

Signature: _____ **Date:** _____