



Health History and Examination Form

Wander Wisconsin is a program of Wisconsin Youth Company, Inc.
(608) 276-9782 (800) 238-1174

This form must be received two weeks prior to scheduled trip.

Send To: Wander Wisconsin
1201 McKenna Boulevard
Madison, Wisconsin 53719

The information on this form is not part of the camper acceptance process, but is gathered to assist us in identifying appropriate care. Any changes to this form should be provided to staff upon participant's arrival at Wander Wisconsin. Provide complete information so that Wander Wisconsin can be aware of your child's needs.

Name _____ Birth date _____ Age _____
Last First Middle

Home address _____
Street address City State Zip

Gender: Male Female

Mother or Guardian _____ Phone _____

Home address _____
(If different from child's) Street address City State Zip

Business address _____ Phone _____
Street address City State Zip

Father or Guardian _____ Phone _____

Home Address _____
(If different from child's) Street address City State Zip

Business address _____ Phone _____
Street address City State Zip

Emergency Contact #1 _____ Phone #1 _____

Relationship _____ Phone #2 _____

Address _____
Street address City State Zip

Emergency Contact #2 _____ Phone #1 _____

Relationship _____ Phone #2 _____

Address _____
Street address City State Zip

Insurance Information

Is the participant covered by family medical/hospital insurance? Yes No

If so, indicate carrier or plan name _____

Group # _____ Policy # _____

ALLERGIES List all known. Describe reaction and management of each reaction.

Medication allergies (list)

Food allergies (list)

Other allergies (list) - include insect stings, hay fever, asthma, animal dander, etc.

MEDICATIONS Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely.

This person **takes NO medications** on a routine basis. OR This person **takes medications** as follows:

Med #1 _____ Reason for taking _____

Med #2 _____ Reason for taking _____

Med #3 _____ Reason for taking _____

Med #4 _____ Reason for taking _____

(Attach additional pages for more medications.)

Identify any medications taken during the school year that participant does/may not take on the trip:

RESTRICTIONS (The following restrictions apply to this individual.)

Does not eat: Red meat Pork Dairy products Poultry Seafood Eggs Other (describe) _____

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)

GENERAL QUESTIONS: Has/does the participant:

Yes No

Yes No

- | | | | | | |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Had a recent injury, illness or infectious disease?..... | <input type="checkbox"/> | <input type="checkbox"/> | 16. Ever had back problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have a chronic or recurring illness/condition? | <input type="checkbox"/> | <input type="checkbox"/> | 17. Ever had problems with joints (e.g. knees, ankles)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Ever been hospitalized?..... | <input type="checkbox"/> | <input type="checkbox"/> | 18. Have an orthodontic appliance being brought to camp? ... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Ever had surgery?..... | <input type="checkbox"/> | <input type="checkbox"/> | 19. Have any skin problems (e.g., itching, rash, acne)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> | 20. Have diabetes? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Ever had a head injury?..... | <input type="checkbox"/> | <input type="checkbox"/> | 21. Have asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Ever been knocked unconscious?..... | <input type="checkbox"/> | <input type="checkbox"/> | 22. Had mononucleosis in the past 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Wear glasses, contacts or protective eye wear? | <input type="checkbox"/> | <input type="checkbox"/> | 23. Had problems with diarrhea/constipation? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Ever had frequent ear infections? | <input type="checkbox"/> | <input type="checkbox"/> | 24. Have problems with sleepwalking? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Ever passed out during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 25. If female, have an abnormal menstrual history? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Ever been dizzy during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 26. Have a history of bed-wetting? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Ever had seizures? | <input type="checkbox"/> | <input type="checkbox"/> | 27. Ever had an eating disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Ever had chest pain during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 28. Ever had emotional difficulties for which | | |
| 14. Ever had high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> | professional help was sought? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Ever been diagnosed with a heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> | (Explain "yes" answers below.) | | |

Please explain any "yes" answers, noting the number of the questions (use additional sheet if necessary) _____

Which of the following has the participant had?

- Measles Hepatitis A
 Chicken pox Hepatitis B
 German measles Hepatitis C
 Mumps

Please give all dates of immunization for:

Vaccine:	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP		_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)		_____	_____	_____	_____	_____	_____
Tetanus		_____	_____	_____	_____	_____	_____
Polio		_____	_____	_____	_____	_____	_____
MMR		_____	_____	_____	_____	_____	_____
Haemophilus influenza B		_____	_____	_____	_____	_____	_____
Hepatitis B		_____	_____	_____	_____	_____	_____
Varicella (Chicken Pox)		_____	_____	_____	_____	_____	_____ (or approximate date of disease)

TB Mantoux Test: Date of last test _____

Result: Positive Negative

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which Wander Wisconsin should be aware (use additional sheet if necessary). _____

Name of family physician _____ Phone _____

Address _____

Name of family dentist/orthodontist _____ Phone _____

Address _____

Parent/Guardian Authorizations*: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all Wander Wisconsin activities except as noted. I hereby give permission to Wander Wisconsin to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give Wander Wisconsin permission to arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by Wander Wisconsin to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for Wander Wisconsin's trip enrollment file.

**If for religious reasons you cannot sign this, contact Wander Wisconsin for a legal waiver which must be signed prior to attendance.*

Signature of parent or guardian **X** _____

Printed Name _____ Date _____

I also understand and agree to abide by any restrictions placed on my participation in program activities.

Signature of camper **X** _____

Health Care Recommendations by Licensed Medical Personnel

I examined the above camp participant on _____. Wander Wisconsin requirements specify exams within 12 months of camp attendance. A new exam is not necessarily required for camp attendance.

BP _____ Weight _____ Height _____ In my opinion, the above applicant is is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions _____

Recommendations and Restrictions at Camp

Treatment to be continued at camp _____

Signature of Licensed Medical Personnel **X** _____ Date _____

Printed Name _____ Title _____

Address _____ Phone _____