CrossWoods Health History Form
For Campers & Adults

Bring when you register: ✓ **This Completed Form** ✓ **Copy of Insurance Card** ✓ **Any medications in labeled containers**

2018

Camper Name _____ Birth Date _____/_____/_____ Age at Camp _____

Home Mailing Address _____
Street *City* *State* *ZIP*

Custodial parent/guardian	*Second parent/guardian or other contact*	*If neither available, in an emergency notify*
_____ *Name*	_____ *Name*	_____ *Name*
Home Phone (_____) _____	Home Phone (_____) _____	Home Phone (_____) _____
Work Phone (_____) _____	Work Phone (_____) _____	Work Phone (_____) _____
Cell Phone (_____) _____	Cell Phone (_____) _____	Cell Phone (_____) _____

Insurance Information
Is this camper covered by medical/hospital/health insurance? ❑ Yes ❑ No
If yes**,** please attach a photocopy of the front and back of the insurance card. And provide the following:

Insurance Carrier _____ Phone (____) _____

Group/Policy Number _____ Name of insured _____

Health History – A parent, legal guardian, physician or nurse practitioner may complete this section.

Physician's Name _____ Phone (_____) _____

This individual is under the care of a physician for the following: _____

_____

_____

_____

Provide month and year for each immunization. Tetanus booster _____ Hepatitis B _____ Polio _____ Haemophilus b (HIB)_____ MMR _____ Varicella (Chicken Pox) _____

This individual has had chicken pox? ❑ Yes ❑ No This individual has had mononucleosis in the past 12 months? ❑ Yes ❑ No

This individual has a history of illness, injury or surgery that will affect participation? ❑ Yes ❑ No

If yes, explain: _____

Allergies - List all known Medication allergies — Describe reaction and management of the reaction:

_____ _____

_____ _____

Food allergies

_____ _____

_____ _____

Other allergies –include insect stings, hay fever, asthma, animal dander, etc…

_____ _____

_____ _____

DIET: ❑ No red meat ❑ No pork ❑ No eggs ❑ No poultry
❑ No seafood ❑ No dairy products ❑ Other _____

(Over)

Name _____

Medications: List **All** medications (*include over the counter/nonprescription*) taken routinely. Bring enough medication for entire camp in original bottle/packaging that identifies prescribing physician (*if prescription*), name of medication, dosage, and frequency. Medications dispensed according to label instructions. If the camper is not taking medication as indicated on the label, get the medication into a container properly labeled by a physician or pharmacist for current dosage. Campers are not allowed to self-medicate, except by necessity (*i.e. inhalers and the like*).

❑ This person takes **NO** medications on a regular basis. ❑ This person **takes** medications on a regular basis (*include over the counter medications*)

Medication Name_____ Dosage_____ Taken daily ❑ Yes ❑ No

Reason taking_____ Date started_____

Medication Name_____ Dosage_____ Taken daily ❑ Yes ❑ No

Reason taking_____ Date started_____

Medication Name_____ Dosage_____ Taken daily ❑ Yes ❑ No

Reason taking_____ Date started_____

Medication Name_____ Dosage_____ Taken daily ❑ Yes ❑ No

Reason taking_____ Date started_____

- - - List any additional medications on a separate sheet. - - -

Ongoing Health Concerns: Check all that pertain to this individual, and provide information about supportive healthcare.

- ❑ This individual has no ongoing health concerns
- ❑ This individual has the following ongoing health concerns
  - ❑ Asthma ❑ Headaches ❑ Sleepwalking ❑ Diabetes ❑ Frequent ear infections
  - ❑ Bedwetting ❑ Pregnancy ❑ Menstrual cramps or related concerns ❑ Other_____

Provide information about supportive health care for each checked item_____

_____

If your child receives care/ medication for emotional, learning and/or psychological concerns, provide background information to help us work with this camper_____

_____

Person completing this form_____ Date_____

Parent Initials

_____ I authorize an adult, in whose care the minor has been entrusted, to consent to X-ray examination, anesthetic, medical, surgical or dental diagnosis and treatment or hospital care for the above named minor. Such care is to be rendered under the general or specific supervision and on the advice of any physician or dentist licensed under the provisions of the Medical Practice Statutes of the State of Wisconsin, if there is insufficient time or inability to contact me. I will be liable and agree to pay all costs and expenses incurred in connection with such medical and dental services rendered pursuant to this authorization.

_____ I give permission for this minor to ride in any vehicle designated by the adult in whose care the minor has been entrusted.

_____ I will take no civil action against CrossWoods, Inc., any associated agencies, or persons in whose care the minor has been entrusted, for normal care of the minor in their charge.

_____ I give permission for this minor to receive non-prescription medications for non-emergency situations from a designated health-care provider.

_____ If my child has a headache, I usually give them _____ *(example: Tylenol, Ibuprofen, etc…)*

Signature of Parent / Legal Guardian _____ Date _____

FOR CAMP USE ONLY --- DO NOT WRITE BELOW THIS LINE

CrossWoods Check-In Nursing Notes

Nurse's Log Entries

_____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

Screening performed by_____ Date_____