

Wildwood Ranch

2008 Camper Health History Form

The following information is requested so that the Ranch and parent can work together to meet the physical, intellectual, and emotional needs of the child. Please fill out all requested information.

Name _____ Birth date _____ Age _____ Sex _____
last first middle

Home Address _____
Street Address City State Zip

Custodial Parent/guardian _____ Phone _____

Home Address _____
Street Address City State Zip

Business address _____ Phone _____
Street address City State Zip

Second parent/guardian or emergency contact _____

Address _____ Phone _____
Street address City State Zip

If not available in an emergency, notify _____

Relationship _____ Phone _____

Insurance Information

Is the participant covered by family medical/hospital insurance? Yes No
If so, indicate carrier or plan name _____ Group # _____

Carrier address _____

Name of insured _____ Relationship to participant _____

Social Security number of policy holder or insurance ID number _____

Allergies Describe reaction and management of the reaction.
Including medication allergies (e.g., penicillin), food allergies (e.g. lactose intolerant), and other allergies (e.g. hay fever, insect stings, asthma, cats)

Are there any known physical limitations? Please list: _____

Medications Being Taken (including psychiatric)

Please list all medications, including over-the-counter medications, that are taken routinely. NOTE: (Very Important!) Please bring medicine to camp in the original bottle. **We will ONLY dispense the medicine according to the doctor's prescription written on the bottle.**

Medicine #1 _____ Dosage _____ Time(s) taken each day _____

Reason for taking _____

Medicine #2 _____ Dosage _____ Time(s) taken each day _____

Reason for taking _____

Are there any medications taken during the school year that the camper does not take during the summer? _____

This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted. I hereby give permission to Wildwood Ranch, which is licensed by the Michigan Department of Human Services, to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests, for the minor child named on this card, while at camp.

Parent's Signature _____ Date _____

General Questions (explain "yes" answers below.)

- | Has/does the camper: | Yes | No |
|--|--------------------------|--------------------------|
| 1. Had any recent injury, illness or infectious disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have a chronic or recurring illness/condition..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Ever been hospitalized?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Ever had surgery?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have frequent headaches?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Ever had a head injury?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Ever been knocked unconscious?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Wear glasses, contacts, or protective eye wear?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Ever had frequent ear infections?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Ever passed out or been dizzy after exercise?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Ever had seizures?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Ever had chest pain during or after exercise?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Ever had high blood pressure?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Ever been diagnosed with a heart murmur?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Ever had back problems?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Ever had problems with joints (e.g. knees, ankles)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Ever had dental problems?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have any skin problems (e.g. itching, rash, acne)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have diabetes?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Have asthma and/or shortness of breath?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Had mononucleosis in the past 12 months?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Had problems with diarrhea/constipation?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Have problems with sleepwalking?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. If female, have an abnormal menstrual history?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Have a history of bedwetting?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Ever had an eating disorder?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Ever had emotional difficulties for which professional help was sought?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Have any communicable diseases?..... | <input type="checkbox"/> | <input type="checkbox"/> |

Please explain any "Yes" answers, noting the number of the question.

Use this to provide any additional information about the camper's behavior, or physical, emotional, mental health:

TB Mantoux Test
Date of last test _____
Result: _____ positive
 _____ negative

Which of the following has the participant had?

- Measles Chicken Pox German Measles Mumps Hepatitis (A, B, or C)

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)		_____	_____	_____	_____	_____	_____

Please print the following information:

Name of family physician _____ Phone _____

Name of family dentist _____ Phone _____