



Camp Winnebago  
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## Health History and Medical Examination

\*\* Please use this checklist to ensure all information is included \*\*

1. **This form is complete and signed.** The camper's **Medical Care Provider (MD, NP, PA)** must review this Health History, complete the Medical Examination, provide recommendations and restrictions for camp, and **sign** on the back of this form. The exam must be within 1 year of camp attendance. **To help us provide the best health care for everyone, this form needs to be completed AND received at least **2 Weeks Prior** to camp session.**
2. **A copy of the camper's med sheet is attached (include standing orders, protocols, etc).** Information on your med sheet does not have to be rewritten on this form, where applicable, note "see med sheet". If med sheet is not available, please provide information in the space provided on this form.  
 → **Note: If the camper's medical appointment delays completion of this form, please fax the health history part of this form and a copy of your med sheet to us 2 weeks before the camp session begins. We will accept this signed form at check-in.**  
 → **Note: PLEASE fax changes to camp.**
- 3 **A copy of the camper's immunization record is attached.**

**Camper's Name:** \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: M / F  
Last                      First                      Middle Initial

**Camper's Address:** \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Street    City                      State                      Zip

**Who should we call 1<sup>st</sup> if we have questions?? Please mark below with a #1, #2, #3, etc. INCLUDE day & night numbers!!!**

**Parent/Guardian:** \_\_\_\_\_ Phone: \_\_\_\_\_  
Circle                      Name    Address

**House Supervisor:** \_\_\_\_\_ **Alternate:** \_\_\_\_\_  
Name    Phone Number(s)    Name    Phone Number(s)

**Agency:** \_\_\_\_\_ **Nurse:** \_\_\_\_\_  
Name                      City                      Phone Number    Name                      Phone Number(s)

**House Supervisor Email:** \_\_\_\_\_ **Nurse Email:** \_\_\_\_\_

**Emergency contact(s) if persons above are not available**    **Name** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
Relationship  
**Name** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
Relationship

### Health History (to be completed by caregiver and reviewed by medical care provider)

Check and provide appropriate dates, provide details, describe treatment or action to be taken, etc.

1. Camper's **medical diagnosis** and/or health conditions? \_\_\_\_\_  
 \_\_\_\_\_

2. Does the camper have a **history of or currently have/use** any of the following?

- |                                 |                                      |                           |                                |
|---------------------------------|--------------------------------------|---------------------------|--------------------------------|
| _____ Hearing Aid(s)            | _____ Diabetes/Blood Sugar √s        | _____ Headaches           | _____ Atlantoaxial instability |
| _____ Ear Infections            | _____ Chest Pain                     | _____ Glasses             | _____ Dentures/Partials        |
| _____ Asthma                    | _____ Back, Joint or Muscle Concerns | _____ Orthotics           | _____ Other: _____             |
| _____ High Blood Pressure       | _____ Shunt _____                    | _____ Fears/Phobias _____ |                                |
| _____ Sexuality Issues/concerns | _____ SIBs _____                     | _____ Seizures _____      | _____ How often _____          |

Describe Seizures/auras and Protocol \_\_\_\_\_  
 \_\_\_\_\_

Other **Operations, Chronic** or **Recurring illnesses/Conditions** (and dates): \_\_\_\_\_  
 \_\_\_\_\_

3. Does the camper have **allergies** (if yes, what might happen if exposed)?  
 Insect bites \_\_\_\_\_ Animals \_\_\_\_\_ Foods \_\_\_\_\_  
 Hay fever/seasonal \_\_\_\_\_ Medication \_\_\_\_\_ Other \_\_\_\_\_  
 Treatment Needed: \_\_\_\_\_

4. **Circle** the type of diet and explain special needs of the camper and preferences or dislikes. Also, discuss any feeding tubes, etc:    Regular / Reg, meat cut into small pieces / Reg, food must be soft / Wt reduction/Low Chol/NAS / Chopped / Pureed / ADA

5. Does the camper have a history of **constipation**? \_\_\_\_\_ (List meds on scheduled and/or prn med list.)  
 Are BMs recorded? \_\_\_\_\_ Describe toileting routine \_\_\_\_\_

Does the camper have a history of **loose stools** or **other bowel** concerns? \_\_\_\_\_ Describe: \_\_\_\_\_

Does the camper have any **bladder** concerns? \_\_\_\_\_ Please describe: \_\_\_\_\_

6. Any other information that would be helpful to camp staff: \_\_\_\_\_

**Scheduled Medications: Please list all medications to be given at camp, prescription and over the counter.**

How does the camper take **PO meds** (whole with liquid, crushed in applesauce, **etc.**)? \_\_\_\_\_

**PR meds** (insert in bed/standing, toilet after 20 minutes/do not toilet?, expect results within 1 hr/overnight, **etc.**)? \_\_\_\_\_

**ANY other information helpful for medication administration** (if this happens, do this; special instructions)? \_\_\_\_\_

Medication (e.g. Depakote Sprinkles)	Strength (e.g. 125 mg)	Qty (e.g. 4 caps)	Route (e.g. po)	Frequency QD, BID, QOD, etc TIMES:	CHECK / ENTER APPROPRIATE TIMES					Purpose/Comments (e.g. to control seizures)
					7A - 9A	11A - 1P	2p - 4P	5P - 6P	7P - 9P	

**As Needed (PRN) Meds at Camp** (include medication, dose, route, frequency and time; include bowel and seizure protocol meds)


**Routine and PRN Treatments** (lotions, creams, drops, etc.), prescription and over the counter, that the camper will need while at camp (include medication, dose, route, frequency, time and special directions):


**Medical/Physical Examination** (This part **must be completed by a licensed medical professional**. The exam must be within 12 months of attendance at camp. Exams for other purposes are acceptable as long as it is within the 12 mo. time frame.)

This examination is for the diagnosis of: \_\_\_\_\_  
and the additional diagnoses of: \_\_\_\_\_

Ht:	Wt:	Pulse:	BP:				
Normal	Abnormalities (list):	Normal	Abnormalities (list):	Normal	Abnormalities (list):	Normal	Abnormalities (list):
Eyes	Glands	Gait					
Ears	Heart	Orthopedic					
Mouth	Lungs	Nervous System					
Nutrition	Abdomen	Reflex					
Throat	Breasts	Extremities					
Dental	Testes	Skin					
Speech	Rectal	Other:					
Allergies (list):						Diet:	

Hepatitis B Carrier: Yes / No    Hepatitis C Carrier: Yes / No    Ring Worm: Yes / No    Athletes Foot: Yes / No  
Is the camper free from other communicable diseases: Yes / No (explain) \_\_\_\_\_

**RECOMMENDATIONS/RESTRICTIONS WHILE AT CAMP:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please check meds that may be given to camper. Meds may be generic, will be given per label & under RN oversight.

Tylenol	Sudafed	Imodium	Milk of Magnesia	Hydrocortisone Cr
Motrin	Actifed	Pepto-Bismol		Caladryl Lotion
Aspirin	Benadryl	Robitussin DM	Neosporin	Betadine

I have examined \_\_\_\_\_ and completed or reviewed this health history. It is my opinion that he/she is physically able to participate in activity at Camp Winnebago, except as noted above.

_____ Examiner's Signature	<i>Examiner's Stamp</i>	_____ Examiner's Address
_____ Printed Name of Examiner (or stamp)		_____ City, State, Zip
_____ Date		_____ Phone Number