|  |
| --- |
| DFRS-BFRB-045.docx (rev. 10/23) |
|  | Wisconsin Department of Agriculture, Trade and Consumer ProtectionDivision of Food and Recreational SafetyP.O. Box 8911, Madison, WI 53708-8911Phone: (608) 224-4720 Fax: (608) 224-4710 |
| CAMPER HEALTH HISTORY RECORD | Wis Admin. Code § ATCP 78.27(1)(d) |
| Use of this form is recommended to meet camper health history record keeping requirements under Wis. Admin. Code ch. ATCP 78. Personally identifiable information may be used for purposes other than for which it is originally being collected. Wis. Stat. § 15.04(1)(m). Failure to keep accurate camper health history records is subject to compliance action under Wis. Admin. Code ch. ATCP 78.  |
| Please return this completed form directly to your Rec Ed Camp. |
| PLEASE PRINT |
| CAMPER’S PERSONAL INFORMATION (please print) |
| FIRST NAME:      | MIDDLE INIT.:      | LAST NAME:       | BIRTHDATE (Mo/Day/Yr.):   /    /      | SEX:      | PRIMARY PHONE NUMBER:(     )     -      |
| MAILING ADDRESS STREET:      | CITY:      | STATE:   | ZIP:      |
| NAME OF PRIMARY PARENT/LEGAL CUSTODIAN IN CASE OF ILLNESS OR INJURY:       | WORK TELEPHONE NUMBER: (     )     -      | CELL PHONE NUMBER:(     )     -      |
| NAME OF SECOND PARENT/LEGAL CUSTODIAN IN CASE OF ILLNESS OR INJURY:       | WORK TELEPHONE NUMBER: (     )     -      | CELL PHONE NUMBER:(     )     -      |
| CAMPER’S HEALTH CARE PROVIDER INFORMATION |
| HEALTH CARE PROVIDER NAME:      |
| MEDICAL FACILITY NAME:      | TELEPHONE NUMBER: (     )     -      |
| [ ]  This camper has no known allergies. |
| [ ]  This camper is allergic to this food(s):      | [ ]  Does this allergy cause anaphylaxis? [ ]  Yes [ ]  No |
| [ ]  This camper is lactose intolerant.       | [ ]  This camper is gluten intolerant.       |
| [ ]  Other (please explain):       |
| [ ]  This camper is allergic to medication(s):       | [ ]  Environment (insect stings, hay fever, etc) | [ ]  Other:       |
| Please describe below what this camper is allergic to and the reaction seen:  |
|       |
| MEDICATION |
| [ ]  This camper will NOT take any medications while attending camp (over the counter or prescribed). |
| [ ]  This camper will take the following medication(s) while attending camp. I am bringing enough medication to last the entire session and it is  in the original container labeled by the pharmacy. |
| Name of Medication | Amount or Dose Given | Reason for Taking It | When It Is Given | How It Is Given | Emergency Medication Only Legal Guardian to initial below if camper is able to carry and self-administer (i.e inhaler, epi-pen) |
|       |       |       | [ ]  Breakfast[ ]  Lunch[ ]  Dinner[ ]  Bedtime[ ]  Other time:  |       |       |
|       |       |       | [ ]  Breakfast[ ]  Lunch[ ]  Dinner[ ]  Bedtime[ ]  Other time:  |       |       |
|       |       |       | [ ]  Breakfast[ ]  Lunch[ ]  Dinner[ ]  Bedtime[ ]  Other time:  |       |       |
| MEDICAL INSURANCE INFORMATION: |
| The camper is covered by family medical/hospital insurance. [ ]  Yes [ ]  No |
| Insurance Company:       | Policy Number:       |
| Subscriber:       | Insurance Company Phone Number: (     )     -      |
| ASTHMA |
| [ ]  This camper does NOT have asthma. | [ ]  This camper does have asthma. |
| Asthma Triggers(check all that apply) | Signs/Symptomsof asthma episode | Frequency of episodes | How episode is managed |
| [ ]  Exercise | [ ]  Colds |       |       |       |
| [ ]  Infections | [ ]  Emotions |
| [ ]  Allergies (to what?)       |
| [ ]  Weather (what type?)       |
| [ ]  Other (list)       |
| IMMUNIZATIONS |
| List the MONTH, DAY, AND YEAR your child received each of the following immunizations. DO NOT USE (√) OR (X) except to answer the question about chickenpox, Tdap or Td. If you do not have an immunization record for this child at home, contact your doctor or public health department to obtain it. A copy of the child’s complete immunization record from the WIR may be attached to this form http://www.dhfswir.org or from healthcare providers, state, or local government are also acceptable. |
| TYPE OF VACCINE\* | FIRST DOSEMo/Day/Yr | SECOND DOSEMo/Day/Yr | THIRD DOSEMo/Day/Yr | FOURTH DOSEMo/Day/Yr | FIFTH DOSEMo/Day/Yr |
| DTaP/DTP/DT/Td (Diphtheria, Tetanus, Pertussis) |       |       |       |       |       |
| Adolescent booster (Check appropriate box)[ ]  Tdap [ ]  Td |       |  |  |  |  |
| Polio (IPV) |       |       |       |       |       |
| Hepatitis B |       |       |       |  |  |
| MMR (Measles, Mumps, Rubella) |       |       |  |  |  |
| Varicella (Chickenpox) Vaccine Vaccine is needed only if your child has not hadChickenpox disease. |       |       | Has your child had Varicella (chickenpox) disease? [ ]  Yes, year: [ ]  No or Unsure (vaccine needed) |
| [ ]  For health reasons, this child is not fully immunized.[ ]  For personal conviction or religious reasons, this child is not fully immunized. \*Include any immunizations received above. |
| RESTRICTIONS: |
| [ ]  I have reviewed the program and activities of the camp and feel the camper can participate without restrictions. |
| [ ]  I have reviewed the program activities of the camp and feel the camper can participate with the following restrictions or adaptations(Please describe below): |
|       |
| OTHER CAMPER CONSIDERATIONS |
| PLEASE INDICATE ANY OTHER IMPORTANT MEDICAL CONDITIONS (eg. Diabetes; seizures; physical conditions; non-prescription medications not to be given; mental, emotional, or social health) |
|       |
| SIGNATURE |
| This health history is correct and accurately reflects the health status of the camper. The person described has permission to participate in all camp activities except as noted by me or an examining physician. I give permission to the camp to provide routine healthcare services, administer medications, and seek emergency services. |
|       |       |
| SIGNATURE – Parent/Guardian/Legal Custodian | DATE |