**UNIVERSITY OF WISCONSIN- MADISON**

**SUMMER YOUTH CAMP HEALTH HISTORY RECORD**

**INSTRUCTIONS TO PARENT:** COMPLETE AND RETURN TO THE CAMP. Contact your child's health care provider or camp Director if you need assistance completing this form.

NAME OF CAMP ATTENDING: _____

**CHILD'S Personal Information**

| Name - Child's (Last, First, Middle Initial) | Birthdate (Mo/Day/Yr) | Telephone Number (Home) ( ) |
|---|---|---|
| Address (Street, City, State, Zip) | | |

| Name of Parent/Guardian/Legal Custodian | Work Telephone Number ( ) | Cellphone Number ( ) |
|---|---|---|
| Name of Emergency Contact | Work Telephone Number ( ) | Cellphone Number ( ) |

**CHILD'S Health Care Provider**

| Health Care Provider Name | Name of Clinic: |
|---|---|
| Address of Facility (Street, City, State, Zip) | Telephone Number ( ) |

**ALLERGIES**

Please check all that apply:

| This child has no known allergies. | This child is allergic to this **food(s):** | This child is allergic to this **medication(s)**: | This child is allergic to the following: _____ |
|---|---|---|---|
| | Does this allergy cause anaphylaxis? Yes No | Does this allergy cause anaphylaxis? Yes No | Does this allergy cause anaphylaxis? Yes No |
| | Date of most recent episode? | Date of most recent episode? | Date of most recent episode? |
| | Describe reaction and how it is managed? | Describe reaction and how it is managed? | Describe reaction and how it is managed? |

**MEDICAL CONDITIONS**

Please check all that apply:

| | | |
|---|---|---|
| **ASTHMA** | This child does **NOT** have asthma. | This child does have asthma and has completed action plan attached. |
| **DIABETES** | This child does **NOT** have diabetes. | This child does have diabetes and has diabetes management plan attached |

**MENTAL HEALTH CONCERNS**

| This child does **NOT** have any mental health concerns. | This child has the following mental health concerns:<br>ADD/ADHD<br>Anxiety<br>Autism Spectrum Disorders<br>Bipolar<br>Depression<br>Eating Disorder<br>Self-Injurious Behavior<br>Other: _____<br><br>Are they currently receiving mental health services?<br><br>YES NO |
|---|---|

**MEDICATION**

This child **will NOT** take any daily medications while attending camp.

Camp health staff may administer over-the-counter medications as needed.

This child **will** take the following medication (includes vitamins, supplements, and over-the-counter) while attending camp.

- I am bringing enough medication to last the entire session
- All medications **MUST** be in the original labeled container and if prescription is labeled by the pharmacy.

| Medication or Treatment | Dose | When do you give it at home? | Reason for taking medication |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**OTHER HEALTH CONCERNS**

Please indicate any other important medical conditions (e.g. seizures, physical conditions, etc.)

SIGNATURE

The information included on this form is complete and accurate to the best of my knowledge.

SIGNATURE- Parent/Guardian/Legal Custodian

Date Signed