Camp Name: _____
Dates: _____

University of Wisconsin-La Crosse

PART ONE:
CONSENT FOR MEDICATION ADMINISTRATION and MEDICAL TREATMENT

TO THE PARENT(S) OR LEGAL GUARDIAN:

If your son, daughter, or ward will be under the age of 18 while at the University of Wisconsin-La Crosse, it is camp policy to secure your consent for medication distribution and for the use of medical devices. The medication or medical device can be self-administered or be administered by the Camp Health Supervisor.

All medications must be in a medicine bottle and labeled with the camper's name, doctor's name and phone number, medication name, and dosage. You must also complete the form below:

_____ No medication has been brought to camp.

_____ I want the medication or medical devices self-administered. (Age 14 and above only.)

_____ I want the medication or medical device administered by the Camp Health Supervisor. However, a limited amount of medication for life threatening conditions may be carried by my son/daughter/ward. (i.e. bee sting kits, inhalers)

_____ _____ .... _____
Name of Medication (s) Prescribing Doctor Doctor's Phone #

_____ _____ _____
Amount to be taken How is it taken? When to be administered

_____ _____
Day(s) to be taken Special Instructions

- If your son, daughter, or ward will be under the age of 18 years while at our camp, it is our policy to secure your consent for medical treatment.
- By signing below you are giving your consent in advance for medical treatment at an appropriate medical facility in case of illness or injury.
- By signing below you are stating that you are aware of and accept the risk inherent in the program activity.
- By signing below you agree to hold harmless and indemnify the Board of Regents of the University of Wisconsin System, and the University of Wisconsin-La Crosse, their officers, employees and agents, from any and all liability, loss, damages, or expenses which are sustained, or required arising out of the actions of your dependent in the course of the camp/event.

_____
Participant Name (Please Print)

_____ _____
Signature of Parent or Guardian Date

PART TWO: HEALTH HISTORY QUESTIONNAIRE

Full Participant Name:

Name of Camp/Event:

Camp Dates:

Full Home Address:

Home Telephone Number:

Date of Birth: ____/____/_____ Sex: M F

Height: Weight:

Parent/Guardian Name:

Relationship:

Address (if different than above)

Home Telephone Number: (if different than above)

Parent/Guardian Work Telephone:

Does participant have allergic reactions to:

❑ Yes ❑ No .....Penicillin
❑ Yes ❑ No .....Other Antibiotics _____
❑ Yes ❑ No .....Other Medicine (type) _____
❑ Yes ❑ No .....Insect Bites/Stings _____

Alternate contact in the event that the Parent/Guardian cannot be contacted during an injury or illness. (Name, Relationship, Address, and Telephone Number)

Physician: _____ Telephone:_____

Insurance Co.: _____ Policy No.: _____

Does participant take medication on a regular basis?

❑ Yes ❑ No If Yes, Identify _____

(consent for medication administration must be signed on reverse.)

Immunization Record

* MMR (measles, mumps, rubella) Dose 1-Immunization at age 1	❑ Yes	❑ No
Dose 2	❑ Yes	❑ No
* Tetanus-Diphtheria	❑ Yes	❑ No
* Year of last tetanus boost (must be within last 10 years)		

Has participant ever had major surgery or been hospitalized? ❑ Yes ❑ No

Please explain any significant operations, accidents or illnesses, and last medical attention and reason:

Does the participant have any physical condition(s) requiring special considerations? Explain.

A physical examination within 24 months of the camp/event is recommended.
Date of participant's last physical examination:_____

Has participant had or presently experiencing:

❑ Yes ❑ No Allergies
❑ Yes ❑ No Asthma
❑ Yes ❑ No Bleeding Disorder
❑ Yes ❑ No Cancer
❑ Yes ❑ No Colitis
❑ Yes ❑ No Diabetes
❑ Yes ❑ No Epilepsy/Seizures/Blackouts
❑ Yes ❑ No Heart Disease
❑ Yes ❑ No Hernia
❑ Yes ❑ No High Blood Pressure
❑ Yes ❑ No Joint Injury/Surgery
❑ Yes ❑ No Kidney Disease
❑ Yes ❑ No Menstrual Difficulties
❑ Yes ❑ No Mental/Emotional Problems
❑ Yes ❑ No Neck/Back Pain/Injury
❑ Yes ❑ No Rheumatic Fever
❑ Yes ❑ No Tuberculosis
❑ Yes ❑ No Ulcer

Other: _____