

**CrossWoods Health History Form  
For Campers & Adults**

**Bring when you register:**    ✓ **This Completed Form**  
 ✓ **Copy of Insurance Card**    ✓ **Any medications in labeled containers**

**2014**

Camper Name \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age at Camp \_\_\_\_\_

Home \_\_\_\_\_  
 Mailing Address \_\_\_\_\_  
Street City State ZIP

<i>Custodial parent/guardian</i>	<i>Second parent/guardian or other contact</i>	<i>If neither available, in an emergency notify</i>
<small>Name</small>	<small>Name</small>	<small>Name</small>
Home Phone (____) _____	Home Phone (____) _____	Home Phone (____) _____
Work Phone (____) _____	Work Phone (____) _____	Work Phone (____) _____
Cell Phone (____) _____	Cell Phone (____) _____	Cell Phone (____) _____

**Insurance Information**

Is this camper covered by medical/hospital/health insurance?     Yes     No

If yes, please attach a photocopy of the front and back of the insurance card. And provide the following:

Insurance Carrier \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Group/Policy Number \_\_\_\_\_ Name of insured \_\_\_\_\_

**Health History** – A parent, legal guardian, physician or nurse practitioner may complete this section.

Physician's Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

This individual is under the care of a physician for the following: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Provide month and year Tetanus booster \_\_\_\_\_ Hepatitis B \_\_\_\_\_ Polio \_\_\_\_\_  
 for each immunization. Haemophilus b (HIB) \_\_\_\_\_ MMR \_\_\_\_\_ Varicella (Chicken Pox) \_\_\_\_\_

This individual has had chicken pox?     Yes     No    This individual has had mononucleosis in the past 12 months?     Yes     No

This individual has a history of illness, injury or surgery that will affect participation?     Yes     No

If yes, explain: \_\_\_\_\_

**Allergies** - List all known                      Describe reaction and management of the reaction:  
 Medication allergies

\_\_\_\_\_

\_\_\_\_\_

Food allergies

\_\_\_\_\_

\_\_\_\_\_

Other allergies –include insect stings, hay fever, asthma, animal dander, etc...

\_\_\_\_\_

\_\_\_\_\_

**DIET:**     No red meat     No pork             No eggs             No poultry  
               No seafood     No dairy products             Other \_\_\_\_\_

Name \_\_\_\_\_

*(Over)*

**Medications:** List **All** medications (*include over the counter/nonprescription*) taken routinely. Bring enough medication for entire camp in original bottle/packaging that identifies prescribing physician (*if prescription*), name of medication, dosage, and frequency. Medications dispensed according to label instructions. If the camper is not taking medication as indicated on the label, get the medication into a container properly labeled by a physician or pharmacist for current dosage. Campers are not allowed to self-medicate, except by necessity (*i.e. inhalers and the like*).

This person takes **NO** medications on a regular basis.       This person **takes** medications on a regular basis (*include over the counter medications*)

Medication Name \_\_\_\_\_ Dosage \_\_\_\_\_ Taken daily  Yes  No

Reason taking \_\_\_\_\_ Date started \_\_\_\_\_

Medication Name \_\_\_\_\_ Dosage \_\_\_\_\_ Taken daily  Yes  No

Reason taking \_\_\_\_\_ Date started \_\_\_\_\_

Medication Name \_\_\_\_\_ Dosage \_\_\_\_\_ Taken daily  Yes  No

Reason taking \_\_\_\_\_ Date started \_\_\_\_\_

Medication Name \_\_\_\_\_ Dosage \_\_\_\_\_ Taken daily  Yes  No

Reason taking \_\_\_\_\_ Date started \_\_\_\_\_

**- - - List any additional medications on a separate sheet. - - -**

**Ongoing Health Concerns:** Check all that pertain to this individual, and provide information about supportive healthcare.

- This individual has no ongoing health concerns
- This individual has the following ongoing health concerns
  - Asthma       Headaches       Sleepwalking       Diabetes       Frequent ear infections
  - Bedwetting       Pregnancy       Menstrual cramps or related concerns       Other \_\_\_\_\_

Provide information about supportive health care for each checked item \_\_\_\_\_

If your child receives care/ medication for emotional, learning and/or psychological concerns, provide background information to help us work with this camper \_\_\_\_\_

Person completing this form \_\_\_\_\_ Date \_\_\_\_\_

*Parent Initials*

\_\_\_\_\_ I authorize an adult, in whose care the minor has been entrusted, to consent to X-ray examination, anesthetic, medical, surgical or dental diagnosis and treatment or hospital care for the above named minor. Such care is to be rendered under the general or specific supervision and on the advice of any physician or dentist licensed under the provisions of the Medical Practice Statutes of the State of Wisconsin, if there is insufficient time or inability to contact me. I will be liable and agree to pay all costs and expenses incurred in connection with such medical and dental services rendered pursuant to this authorization.

\_\_\_\_\_ I give permission for this minor to ride in any vehicle designated by the adult in whose care the minor has been entrusted.

\_\_\_\_\_ I will take no civil action against CrossWoods, Inc., any associated agencies, or persons in whose care the minor has been entrusted, for normal care of the minor in their charge.

\_\_\_\_\_ I give permission for this minor to receive non-prescription medications for non-emergency situations from a designated health-care provider.

\_\_\_\_\_ If my child has a headache, I usually give them \_\_\_\_\_ (*example: Tylenol, Ibuprofen, etc...*)

Signature of Parent / Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

**FOR CAMP USE ONLY --- DO NOT WRITE BELOW THIS LINE**

*CrossWoods Check-In Nursing Notes*

*Nurse's Log Entries*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Screening performed by \_\_\_\_\_ Date \_\_\_\_\_