

Medical Information 2012



Office Use Only
Name: _____
Session: _____

TO BE COMPLETED BY A MEDICAL PHYSICIAN

Camper's Name _____
 Address _____
 City _____ State _____ Zip _____
 Camper Phone (_____) _____
 Name _____

Date of Exam _____
 Date of Birth _____ Age at Camp _____
 Male _____ Female _____
 Medical Diagnosis: _____

(Parent, Guardian, or Houseparent)
 Medical Assistance/I.D. #: _____
 - or -
 Insurance Company: _____

Insurance #: _____ Group#: _____
 Insured's Name: _____

Height _____ Weight _____ BP _____ P _____ T _____ R _____

Is the following normal? (Yes or No) If no, explain:

1. Ears _____
2. Nose _____
3. Throat _____
4. Skin _____
5. Eyes _____
6. Scalp _____
7. Heart _____
8. Lungs _____
9. Extremities _____
10. Abdomen _____
11. Varicosities _____
12. Genitalia _____
13. Neurologic _____

Is there a history of? (Yes or No) If yes, explain:

1. Asthma _____
 2. Hernia _____
 3. Recent Illness _____
 4. Kidney Disease _____
 5. Diabetes _____
 6. TB _____
 7. Stomach Disorders _____
 8. Frequent colds or hay fever _____
 9. Hepatitis _____
 10. Heart Disease _____
 11. Previous surgery _____
- Comments: _____

Non-Drug Allergies: _____ / _____ / _____
 Reactions: _____ / _____ / _____
 Blood/Body Fluid Precaution? _____ Yes _____ No If Yes, Type _____

Does this person have seizures or convulsions? _____ If yes,
 frequency _____
 Type _____ Last seizure _____
 At what point do we call the EMS? _____

WILL THIS PERSON BE RECEIVING MEDICATION WHILE AT CAMP? If yes, please fill in the following or send a copy of the Medication Administration Record (MAR): (ATTACH ADDITIONAL SHEETS IF NEEDED)

Name of medication	Dosage (milligrams/# of pills)	Time(s)	Purpose	Other directions (route, crushed, with applesauce, etc)

Current health conditions requiring medication, treatment or special considerations while at camp: _____

Drug Allergies: _____ / _____ / _____
 Reactions: _____ / _____ / _____

May this person be given any of the following if the need arises?

	Use Generic					Use Generic			
	Yes	No	Yes	No		Yes	No	Yes	No
Pepto Bismol	_____	_____	_____	_____	Antihistamine	_____	_____	_____	_____
Kaopectate	_____	_____	_____	_____	Decongestant	_____	_____	_____	_____
Milk of Magnesia	_____	_____	_____	_____	Cough Syrup	_____	_____	_____	_____
Antacid	_____	_____	_____	_____	Aspirin	_____	_____	_____	_____
Immodium	_____	_____	_____	_____	Ibuprofen	_____	_____	_____	_____
Fleets enema	_____	_____	_____	_____	Acetaminophen	_____	_____	_____	_____
Glycerin suppository	_____	_____	_____	_____					

Does this person have any physical disabilities? _____ If so, please describe _____

Does this person use any special equipment (wheelchair, walker, dentures, hearing aid, etc)? _____

Has this person been immunized against the following? If so, list the most recent date.

MMR #1 _____ MMR #2 _____ Tetanus _____ TB skin test _____

Hep B Vaccine #1 _____ Hep B Vaccine #2 _____ Hep B Vaccine #3 _____

If not immunized for tetanus in the past 10 years, please do so prior to camp attendance.

RESTRICTIONS:

Diet

Swimming

Strenuous Exercise

Hiking

Other Restrictions

ANY FURTHER RECOMMENDATIONS: _____

Physician's Signature: _____, M.D. Date: _____

Print Physician's name: _____ Phone (____) _____

This form must be returned to Wisconsin Badger Camp at least three weeks before camp attendance. Campers WILL NOT be registered unless we have this form. This is to insure that proper medical health care is given by our medical team.

When applicant comes to camp, the nurses will collect all medications. **Be sure all medications are labeled clearly with the camper's name, name of medication, dosage, Pharmacy name and phone number, Physician's name, and time medication is to be taken.** The health care staff will administer all medicine and any medicine not used will be returned home with the camper. Please send an adequate supply.

Before June 4, all forms should be mailed to:

**Wisconsin Badger Camp
PO Box 723
Platteville, WI 53818**

After June 4, mail to:

**Wisconsin Badger Camp
11815 Munz Lane
Prairie du Chien, WI 53821**