



**Medical Information  
Staff 2012**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: (\_\_\_\_\_) \_\_\_\_\_ Age at Camp: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Parent or Guardian: \_\_\_\_\_  
Date of Exam: \_\_\_\_\_

**TO BE COMPLETED BY A MEDICAL PHYSICIAN**

1. Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_ P \_\_\_\_\_ T \_\_\_\_\_

2. Does the applicant show the following to be normal?  
(yes or no). Please Explain.

- a. Ears \_\_\_\_\_
- b. Nose \_\_\_\_\_
- c. Throat \_\_\_\_\_
- d. Skin \_\_\_\_\_
- e. Eyes \_\_\_\_\_
- f. Scalp \_\_\_\_\_
- g. Heart \_\_\_\_\_
- h. Lungs \_\_\_\_\_
- i. Extremities \_\_\_\_\_
- j. Glands \_\_\_\_\_
- k. Abdomen \_\_\_\_\_
- l. Varicosities \_\_\_\_\_
- m. Genitalia \_\_\_\_\_

Allergies: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Reactions: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

3. Is there a history of? (yes or no)

- a. Asthma \_\_\_\_\_
- b. Hernia \_\_\_\_\_
- c. Recent Illness \_\_\_\_\_
- d. Kidney Disease \_\_\_\_\_
- e. Diabetes \_\_\_\_\_
- f. TB \_\_\_\_\_
- g. Stomach Disorders \_\_\_\_\_
- h. Frequent colds or hay fever \_\_\_\_\_
- i. Hepatitis \_\_\_\_\_
- j. Heart Disease \_\_\_\_\_
- k. Previous surgery \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Does the applicant have seizures or convulsions? \_\_\_\_\_

Type \_\_\_\_\_ Frequency \_\_\_\_\_

5. Will the applicant receive ongoing treatment while at camp? \_\_\_\_\_

6. Will the applicant receive medication at camp? \_\_\_\_\_

If yes, fill in the following:

NAME OF DRUG	DOSAGE	TIME OF DAY GIVEN	OTHER DIRECTIONS
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

7. Does the applicant have any limitations? \_\_\_\_\_ If so, describe: \_\_\_\_\_

\_\_\_\_\_

8. Was the applicant immunized against the following? If so, when? **Bring a copy of immunization records to camp.**

Most Recent  
Tetanus \_\_\_\_\_ MMR #1 \_\_\_\_\_ MMR #2 \_\_\_\_\_ TB skin test \_\_\_\_\_

Hep B Vaccine #1 \_\_\_\_\_ Hep B Vaccine #2 \_\_\_\_\_ Hep B Vaccine #3 \_\_\_\_\_

9. Do you have any recommendations in relation to the above information that should be followed during the camping period?

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

10. Are there any current health conditions requiring medication, treatment or special considerations while at camp?

\_\_\_\_\_

RESTRICTIONS: (Explain in detail)

Diet \_\_\_\_\_

\_\_\_\_\_

Swimming \_\_\_\_\_

\_\_\_\_\_

Strenuous Exercise \_\_\_\_\_

\_\_\_\_\_

Other Restrictions \_\_\_\_\_

\_\_\_\_\_

ANY FURTHER RECOMMENDATIONS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Physician's Signature: \_\_\_\_\_, M.D. Date: \_\_\_\_\_

Print Physician's Name: \_\_\_\_\_

Physician's Phone Number: (\_\_\_\_\_) \_\_\_\_\_

All forms should be mailed to: Wisconsin Badger Camp, PO Box 723, Platteville, WI 53818 or brought to camp on the first day of employment.

Thank you for your cooperation.