



**Medical Information
Staff 2008**

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 (last test results) _____
- 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 _____

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.