



PRECOLLEGE CAMPER HEALTH INFORMATION

PARENT INFORMATION

PARENT/GUARDIAN NAME*:	CAMP/EVENT*:
RELATIONSHIP*:	HOME PHONE*:
CELL PHONE*:	EMAIL*:
ADDRESS*:	CITY*:
STATE, ZIP CODE*:	COUNTRY*:

CHILD INFORMATION

CHILD NAME*:	DATE OF BIRTH (mm/dd/yyyy) *:
GENDER*:	HEIGHT (ft.), WEIGHT (lb.) :
ADDRESS*: (if same as parent's, write "same")	CITY*:
STATE, ZIP CODE*:	COUNTRY*:

EMERGENCY CONTACT

NAME*:	RELATIONSHIP*:	PHONE*:
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INSURANCE & DOCTOR INFORMATION

PRIMARY CARE PROVIDER*:	PHONE*:
DENTIST *:	PHONE*:
ORTHODONTIST*:	PHONE*:
INSURANCE COMPANY*:	POLICY NUMBER*:
GROUP/ID NUMBER*:	NAME OF POLICY HOLDER*:

ALLERGY INFORMATION (skip if no allergies)

ALLERGY TYPE:	DRUG	ENVIRONMENTAL	FOOD	LIFE THREATENING?
ALLERGIC TO:				REACTION:

ALLERGY TYPE:	DRUG	ENVIRONMENTAL	FOOD	LIFE THREATENING?
ALLERGIC TO:				REACTION:

If your child has more than 2 allergies, please type out the remaining allergies on a separate piece of paper specifying the above information for each.

*** Information is Required**

RESTRICTIONS (put an "X" in all that apply)

DIET*:	<input type="checkbox"/> NONE	<input type="checkbox"/> VEGETARIAN	<input type="checkbox"/> VEGAN	<input type="checkbox"/> KOSHER	<input type="checkbox"/> OTHER: Please specify,	
ACTIVITY*:	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Please describe,			

MEDICATION INFORMATION (skip if no medications)

By Wisconsin state law, medication must be administered by the camp staff to all campers under age 18.

MEDICATION TYPE:	<input type="checkbox"/> PRESCRIPTION	<input type="checkbox"/> OVER THE COUNTER	STRENGTH:		DOSE:	
MEDICATION NAME:			TIME(S) TO GIVE: <small>(breakfast, lunch, dinner, as needed)</small>			
DATES TO GIVE MEDICATION:			DETAILS:			

MEDICATION TYPE:	<input type="checkbox"/> PRESCRIPTION	<input type="checkbox"/> OVER THE COUNTER	STRENGTH:		DOSE:	
MEDICATION NAME:			TIME(S) TO GIVE: <small>(breakfast, lunch, dinner, as needed)</small>			
DATES TO GIVE MEDICATION:			DETAILS:			

If your child has more than 2 medications, please write out the remaining medications on a separate piece of paper specifying the above information for each.

MEDICAL HISTORY (put an "X" in all that apply)

Hospitalized	Fainting/dizziness
Surgery	Passed out/had chest pain during exercise
Recurrent/chronic illnesses	"Mono" in the last 12 months
Recent infectious disease	Problems with menstruation
Recent injury	Problems with falling asleep/waking
Asthma/wheezing/shortness of breath	Back/joint problems
Diabetes	History of bedwetting
Seizures	Problems with diarrhea/constipation
Headaches	Skin problems
Glasses/contacts/protective eyewear	Traveled outside country in past 9 months
Details:	

Authorization/Consent

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 in the event the medical treatment is warranted. By signing you are giving your consent in advance for the medical treatment at an appropriate medical facility in care of illness or injury. By signing you are stating that you are aware of and accept the risk inherent in the program activity. By signing you agree to hold harmless and indemnify the state of Wisconsin, the board of Regent of the University of Wisconsin System, and the University of Wisconsin - Whitewater, their officers, agents and employees, from any and all liability, loss, damages, costs of expenses which are sustained, incurred or required arising out of the action of your dependent in the course of camp/event.
By providing your signature you authorize us to update your child's health information.

<input type="checkbox"/> I agree*	Parent/Guardian First Name*:	Parent/Guardian Last Name*:	Relationship*:
Parent/Guardian Signature:			Today's Date*:
<input type="checkbox"/> I agree*	Student First Name*:	Student Last Name*:	
Student Signature:			Today's Date*:

Please attach your child's immunization record to this form.

* Information is Required