

University of Wisconsin _____

**PART ONE:
 CONSENT FOR MEDICATION ADMINISTRATION
 and MEDICAL TREATMENT**

TO THE PARENT(S) OR LEGAL GUARDIAN:

If your son, daughter, or ward will be under the age of 18 while at the University of Wisconsin-_____, it is camp policy to secure your consent for medication distribution and for the use of medical devices. The medication or medical device can be self-administered or be administered by the Camp Health Supervisor.

All medications must be in a medicine bottle and labeled with the camper's name, doctor's name and phone number, medication name, and dosage. You must also complete the form below:

- _____ No medication has been brought to camp.
- _____ I want the medication or medical devices self-administered. (Age 14 and above only.)
- _____ I want the medication or medical device administered by the Camp Health Supervisor. However, a limited amount of medication for life threatening conditions may be carried by my son/daughter/ward. (i.e. bee sting kits, inhalers)

Name of Medication (s)	Prescribing Doctor	Doctor's Phone #
_____	_____	_____
Amount to be taken	How is it taken?	When to be administered
_____	_____	_____
Day(s) to be taken	Special Instructions	
_____	_____	

- 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 for medical treatment.
- By signing below you are giving your consent in advance for medical treatment at an appropriate medical facility in case of illness or injury.
- By signing below you are stating that you are aware of and accept the risk inherent in the program activity.
- By signing below you agree to hold harmless and indemnify the Board of Regents of the University of Wisconsin System, and the University of Wisconsin-_____, their officers, employees and agents, from any and all liability, loss, damages, or expenses which are sustained, or required arising out of the actions of your dependent in the course of the camp/event.

Participant Name (Please Print) _____

Signature of Parent or Guardian _____

_____ Date

PART TWO: HEALTH HISTORY QUESTIONNAIRE

Full Participant Name:	Social Security Number:	Name of Camp/Event	Camp Dates
Full Home Address:	Home Telephone Number:	Date of Birth: ____/____/____	Sex: M F
Parent/Guardian Name:	Relationship:	Height:	Weight:
Address (if different than above)	Home Telephone Number: (if different than above)	Does participant have allergic reactions to:	
	Parent/Guardian Work Telephone:	<input type="checkbox"/> Yes <input type="checkbox"/> No Penicillin <input type="checkbox"/> Yes <input type="checkbox"/> No Other Antibiotics _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Other Medicine (type) _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Insect Bites/Stings _____	
Alternate contact in the event that the Parent/Guardian cannot be contacted during an injury or illness. (Name, Relationship, Address, and Telephone Number)			
Physician: _____ Telephone: _____			
Insurance Co.: _____ Policy No.: _____			
Immunization Record			
* MMR (measles, mumps, rubella) <input type="checkbox"/> Yes <input type="checkbox"/> No			
Dose 1-Immunization at age 1 <input type="checkbox"/> Yes <input type="checkbox"/> No			
Dose 2 <input type="checkbox"/> Yes <input type="checkbox"/> No			
* Tetanus-Diphtheria <input type="checkbox"/> Yes <input type="checkbox"/> No			
* Year of last tetanus boost (must be within last 10 years)			
Has participant ever had major surgery or been hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Please explain any significant operations, accidents or illnesses, and last medical attention and reason:			
Does the participant have any physical condition(s) requiring special considerations? Explain.			
A physical examination within 24 months of the camp/event is recommended.			
Date of participant's last physical examination: _____			
Does participant take medication on a regular basis? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Identify _____ (consent for medication administration must be signed on reverse.)			
Has participant had or presently experiencing: <input type="checkbox"/> Yes <input type="checkbox"/> No Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No Colitis <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy/Seizures/Blackouts <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No Joint Injury/Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Menstrual Difficulties <input type="checkbox"/> Yes <input type="checkbox"/> No Mental/Emotional Problems <input type="checkbox"/> Yes <input type="checkbox"/> No Neck/Back Pain/Injury <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No Ulcer Other: _____			