Medical & Emergency Contact Information Form

This information will be extremely important in the event of an accident or medical emergency. Please be sure to sign and date this form.

Name:

_____

Last First MI

Phone:

Home: _____ Cell: _____

Home Email Address:_____

Address:_____

Street City State Zip

Primary Emergency Contact Name:_____

Last First

Relationship: _____

Phone: Home: _____ Cell: _____ Work: _____

Secondary Emergency Contact

Name:_____

Last First

Relationship: _____

Phone: Home: _____ Cell: _____ Work: _____

Preferred Local Hospital: _____

Insurance Information: Company: _____ Policy #: _____

MEDICATIONS

Will camper be taking medications while at camp? Yes ___ No ___
(Medications include prescription, over-the-counter, vitamins, inhalers, etc.)

If camper will be taking medications while at camp, it is Wisconsin state law to secure your consent for medication distribution and for the use of medical devices. The medication can be self-administered (if over 18) or administered by Health Services Staff. Please list all (prescription and non-prescription). Include the medication name, prescribing physician, physicians' phone number, and the dosage instructions. Use an additional sheet if needed. When you check-in at camp, please provide all medications (in their original packaging that identifies the prescribing physician (if prescription drug), the name of the medication, the dosage, and frequency of administration.

_____ I want the medication or medical devices self-administered. (Age 18 and above only.)
_____ I want the medication or medical device administered by the Health Services Staff. However, a limited amount of medication for life threatening conditions should be carried by my son/daughter/ward. (i.e. bee sting kits, inhalers)

Medication_____ Dosage_____ Take at what times_____
Reason for Taking_____
Prescribing Physician_____ Phone_____

Medication_____ Dosage_____ Take at what times_____
Reason for Taking_____
Prescribing Physician_____ Phone_____

Medication_____ Dosage_____ Take at what times_____
Reason for Taking_____
Prescribing Physician_____ Phone_____

ALLERGIES

Please list any known allergies.

_____

_____

_____

HEALTH HISTORY

Please know that we value your privacy. Health History information is available only to the camp health staff. The more information you provide, the better we can do our job.

_____

_____

_____

Date of Last Physical Exam (Recommended within 24 months of camp)_____

Physical Activities to be Limited or Restricted while at Camp

_____

AUTHORIZATION

My child has permission to engage in all prescribed camp activities except as noted. The information provided on this form is accurate to the best of my knowledge. I have indicated any special health conditions, including required medication and activity limitations which should be known to the camp staff and medical personnel. I am aware of and accept the risk inherent in the program activity. I give consent in advance for medical treatment at an appropriate facility in case of illness or injury.

Signature: _____ Date: _____