



**D.**

Restrictions

**General Questions:** (Explain "yes" answers below.)

**Has/does the participant:**

- |  | Yes/No |  | Yes/No |
|--|--------|--|--------|
| 1. Have any recent injury, illness or infectious disease? .. | Y / N  | 16. Ever been diagnosed with a heart murmur? ..  | Y / N  |
| 2. Have a chronic or recurring illness/condition? .....      | Y / N  | 17. Ever had back problems? .....                | Y / N  |
| 3. Ever been hospitalized? .....                             | Y / N  | 18. Ever had problems with joints? .....         | Y / N  |
| 4. Ever had surgery? .....                                   | Y / N  | 19. Wear a removable orthodontic appliance? ...  | Y / N  |
| 5. Have frequent headaches? .....                            | Y / N  | 20. Have any skin problems? .....                | Y / N  |
| 6. Ever have a head injury? .....                            | Y / N  | 21. Have diabetes? .....                         | Y / N  |
| 7. Ever been knocked unconscious? .....                      | Y / N  | 22. Have asthma? .....                           | Y / N  |
| 8. Wear glasses, contacts, or protective eye wear? .....     | Y / N  | 23. Had mononucleosis in the past 12 months? ..  | Y / N  |
| 9. Ever had frequent ear infections? .....                   | Y / N  | 24. Had problems with diarrhea/constipation? ... | Y / N  |
| 10. Ever passed out during or after exercise? .....          | Y / N  | 25. Have problems with sleepwalking? .....       | Y / N  |
| 11. Ever been dizzy during or after exercise? .....          | Y / N  | 26. If female, abnormal menstrual history? ..... | Y / N  |
| 12. Ever had seizures? .....                                 | Y / N  | 27. Have a history of bed-wetting? .....         | Y / N  |
| 13. Ever had chest pain during or after exercise? .....      | Y / N  | 28. Ever had an eating disorder? .....           | Y / N  |
| 14. Ever had high blood pressure? .....                      | Y / N  | 29. Ever had emotional difficulties for which    |        |
| 15. Ever had bleeding/clotting disorder? .....               | Y / N  | professional help was sought? .....              | Y / N  |

**Please explain "yes" answer(s), noting the number of the question(s).**

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**Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware.**

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**E.**

General Questions

**RESTRICTIONS**

**The following restrictions apply to this individual:**

**Dietary, circle all that apply**

Does not eat red meat

Does not eat pork

Does not eat eggs

Does not eat poultry

Does not eat seafood

Does not eat dairy products

Other (describe) \_\_\_\_\_

Explain any restrictions to activity (e.g., what cannot be done, what adaptations or limitations are necessary).

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# F. Health Examination Record

To Be Completed by a Licensed Physician, Physician's Assistant, or Registered Nurse. This examination should be performed within 12 months of arrival at camp.

## Wisconsin United Methodist Special Needs Camps

### Please Print

Name \_\_\_\_\_ (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle)

Date of Birth \_\_\_\_\_ General Appearance \_\_\_\_\_

### Health History: (Check all that apply)

Asthma _____	Allergies-Reactions (Describe)
Bleeding/clotting disorders _____	Latex _____
Diabetes _____	Bee stings _____
Frequent ear infections _____	Environmental _____
Heart defects/disease _____	Medications _____
Seizures (type/frequency) _____	Foods _____
Fainting _____	Other _____
Please describe all that are checked: _____	Other _____

Surgeries or serious injuries (dates) \_\_\_\_\_

Any specific activities to be encouraged? \_\_\_\_\_  
 restricted? \_\_\_\_\_

Diagnoses of any current, chronic, or recurring conditions (i.e., frequent colds, sore throat, stomach upset, constipation, diabetes, heart abnormalities, etc.) \_\_\_\_\_

Current treatments or therapies other than oral medications (including topical ointments, physical therapy, counseling, specific approaches to common problems specific to this camper, etc.) \_\_\_\_\_

### Classification For Physical Activity

- Regular \_\_\_\_\_
- Restricted (eliminate strenuous activity) \_\_\_\_\_
- Corrective (individual exercises) \_\_\_\_\_
- Suggestions \_\_\_\_\_
- Complete Rest (restricted to sitting/walking) \_\_\_\_\_
- One-to-one Supervision for all bathing and water activities \_\_\_\_\_

### Diseases - Immunizations/Dates

Chicken pox \_\_\_\_\_  
 Measles \_\_\_\_\_  
 Mumps \_\_\_\_\_  
 German measles/3 day \_\_\_\_\_  
 Rubella \_\_\_\_\_  
 Hepatitis \_\_\_\_\_  
 Tetanus \_\_\_\_\_  
 A B C \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

S = Satisfactory NS = Not Satisfactory O = Not

Skin _____	Thyroid Gland _____	Bones/Muscles _____	Abdomen _____
Scalp _____	Lymph Glands _____	Spine _____	Scars _____
Eyes _____	Breasts - Chests _____	Upper Extremities _____	Abnormalities _____
Ears _____	Deformity _____	Lower Extremities _____	Hernia _____
Naso-Pharynx _____	Lungs _____	Feet _____	Genitalia _____
Abnormalities _____	Urine _____	Posture _____	Abnormalities _____
Tonsils _____	Albumin _____	Cardiovascular _____	Neurological _____
Mouth _____	Specific Gravity _____	Blood Pressure _____	Reflexes _____
Teeth _____	Sugar _____	Pulse _____	Tremor _____
Gums _____	Microscopic _____	Heart Abnormalities _____	Tics, etc. _____
			Other _____

### Physician's Report Regarding Significant Findings of Health Examination:

Signature/Examining Physician: \_\_\_\_\_

Date \_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

## G. PICK-UP AUTHORIZATION

\_\_\_\_\_ is authorized to pick-up \_\_\_\_\_  
(Name of person authorized to pick-up camper) (Camper Name)  
at the conclusion of camp.

\_\_\_\_\_  
Signature of Parent/Guardian Date

## H. MEDICATION AUTHORIZATION

Any prescription or over-the-counter medications brought to camp need to be in original containers and listed on this form.

Camper Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Camp #: \_\_\_\_\_

Name of Medication \_\_\_\_\_ Date Prescribed \_\_\_\_\_

Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Method of Administration: \_\_\_\_\_ Duration: \_\_\_\_\_

Possible Side Effects: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

Why has this medication been prescribed? \_\_\_\_\_

Contact the Physician When: \_\_\_\_\_

Name of Medication \_\_\_\_\_ Date Prescribed \_\_\_\_\_

Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Method of Administration: \_\_\_\_\_ Duration: \_\_\_\_\_

Possible Side Effects: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

Why has this medication been prescribed? \_\_\_\_\_

Contact the Physician When: \_\_\_\_\_

Name of Medication \_\_\_\_\_ Date Prescribed \_\_\_\_\_

Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

Method of Administration: \_\_\_\_\_ Duration: \_\_\_\_\_

Possible Side Effects: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

Why has this medication been prescribed? \_\_\_\_\_

Contact the Physician When: \_\_\_\_\_

Please label **ALL** medications clearly including the following information and keep in original containers:

1) Camper or staff member name; 2) Name of medication; 3) Dosage; 4) Frequency of administration; 5) Method of administration;  
*and*

If the medication has been prescribed by a physician, the label *must* also include:

6) Name of prescribing physician; 7) Prescription number; 8) Date prescribed; 9) Possible adverse reactions; 10) Specific conditions when contact should be made with physician; 11) Other special instructions:

### TO BE FILLED IN BY CAMP HEALTH SUPERVISOR

List routine treatment required during camp period, for example, further examination, special food, injections, or prescriptions:

Record of illness or accidents:

DATE	COMMENT	TREATMENT
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Conditions arising in camp which should be called to the attention of the parents or guardians:

Record medical reimbursement claims: \_\_\_\_\_

Signature of Camp Health Supervisor \_\_\_\_\_ Date \_\_\_\_\_

(For insurance purposes, this record should be kept on file in the camp site office.)

