

Camp Tamarack
E879 Golke Rd.
Waupaca, WI 54981-9723

LEADER ANNUAL HEALTH HISTORY FORM - 2021

ALL CAMPERS MUST FILE THIS FORM EACH YEAR

An up-to-date Health History for all campers is required by State Law.
This form must be completed and signed by a parent/guardian and presented
to the Camp Health Officer upon arrival at camp.

Name of Leader _____ Sex **M - F**
First Middle Last Circle one

Address _____

City _____ State _____ Zip Code _____

Age _____ Birthday _____ / _____ / _____
Month Day Year

Parent/Guardian Name (if under 18) _____

Address _____

City _____ State _____ Zip _____ Emergency Phone _____

If not available in an emergency, notify: _____

Phone _____ / _____

Name of Family Physician _____ Phone _____ / _____

Medical Insurance Carrier _____ Phone number _____

Policy Number _____ Group Number _____

LEADER HEALTH HISTORY

LIST MEDICATIONS – NAME OF MEDICATION, DOSE, AND FREQUENCY

Medication Name	Dose	Frequency

ALLERGIES: _____

IMMUNIZATION RECORD

VACCINES

Does camper have current vaccines? YES _____ NO _____

Tetanus YES _____ DATE _____

COVID Date of shot #1 _____ Date of shot #2 _____ Manufacturer _____

Important: Please notify the camp if the leader is exposed to any communicable disease during the three weeks prior to camp.

If the leader has ANY classic COVID symptoms: Fever or chills, Cough, Shortness of breath or difficulty breathing, Fatigue, Muscle or body aches, Headache, New loss of taste or smell, Sore throat, Congestion or runny nose, Nausea or vomiting, Diarrhea – DO NOT come to camp as we will send the leader home immediately.

I give permission for Camp Tamarack personnel to administer the following non-prescription medication to the leader as needed. Dosage will be based on age and weight. Please cross out any items, which are not acceptable.

Acetaminophen or Ibuprofen
Antibiotic ointment

Sore throat lozenges
Benadryl topical ointment
Benadryl oral

Calamine lotion
Anti-Itch ointment

I also give permission to the physician selected by the camp to order x-rays, routine tests and treatment for the health of the above named camper. In the event I cannot be reached in an emergency, I hereby give my permission to the physician selected to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for the above named camper.

I understand that the camp does not carry health/accident insurance and I accept responsibility for the cost of any medical care provided whether or not it is covered by my family medical/hospital insurance.

I also give my permission for the use of pictures including above leader to be used in promotional camping displays and brochures, without monetary reimbursement.

I certify that the information in this Health History is correct.

Date _____

Leader or Parent/Guardian Signature _____