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

## CAMPER ANNUAL HEALTH HISTORY FORM - 2022

***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 Camper** _____ **Sex M - F**
**First Middle Last Circle one**

**Address** _____

**City** _____ **State** _____ **Zip Code** _____

**Age** _____ **Birthday** _____/_____/_____
**Month Day Year**

**Parent/Guardian Name** _____

**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**_____

## CAMPERS HEALTH HISTORY

**LIST MEDICATIONS – NAME OF MEDICATION, DOSE, AND FREQUENCY**

| Medication Name | Dose | Frequency |
|---|---|---|
| Medication Name | Dose | Frequency |
| Medication Name | Dose | 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_____**

**Booster_____ Manufacturer _____**

**<u>Important</u>: Please notify the camp if this camper is exposed to any communicable disease during the three weeks prior to camp.**

**If the camper 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 camper home immediately.**

The camper named has permission to participate in all prescribed camp activities except as noted below.

Exceptions (if any):_____

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

| | | |
|---|---|---|
| **Acetaminophen or Ibuprofen** | **Sore throat lozenges** | **Calamine lotion** |
| **Antibiotic ointment** | **Benadryl topical ointment** | **Anti-Itch ointment** |
| | **Benadryl oral** | |

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.

Person picking up camper is: _____

Person/persons who cannot pick up camper: _____

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

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

_____ **Date** _____

**Parent/Guardian Signature**