CrossWoods Health History Form
For Campers & Adults

Bring when you register: ✓ This Completed Form
✓ Copy of Insurance Card ✓ Any medications in labeled containers

Camper Name ____________________ Birth Date _____/_____/__________ Age at Camp _________

Home
Mailing Address ____
Street *City* *State* *ZIP*

Custodial parent/guardian	*Second parent/guardian or other contact*	*If neither available, in an emergency notify*
____________________ *Name*	____________________ *Name*	____________________ *Name*
Home Phone (______) ______________	Home Phone (______) ______________	Home Phone (______) ______________
Work Phone (______) ______________	Work Phone (______) ______________	Work Phone (______) ______________
Cell Phone (______) ______________	Cell Phone (______) ______________	Cell Phone (______) ______________

Insurance Information
Is this camper covered by medical/hospital/health insurance? ❑ Yes ❑ No
If yes**,** please attach a photocopy of the front and back of the insurance card. And provide the following:

Insurance Carrier ______________________________ Phone (____) ____________________

Group/Policy Number ______________________________ Name of insured ______________________________

Health History – A parent, legal guardian, physician or nurse practitioner may complete this section.

Physician's Name ______________________________ Phone (______) ____________________

This individual is under the care of a physician for the following: ______________________________

____

____

____

Provide month and year Tetanus booster ____________________ Hepatitis B ____________________ Polio ____________________

for each immunization. Haemophilus b (HIB)____________ MMR ______________ Varicella (Chicken Pox) ______________

This individual has had chicken pox? ❑ Yes ❑ No This individual has had mononucleosis in the past 12 months? ❑ Yes ❑ No

This individual has a history of illness, injury or surgery that will affect participation? ❑ Yes ❑ No

If yes, explain: ____

Allergies - List all known Medication allergies

Describe reaction and management of the reaction:

____________________ ____

____________________ ____

Food allergies

____________________ ____

____________________ ____

Other allergies –include insect stings, hay fever, asthma, animal dander, etc…

____________________ ____

____________________ ____

DIET: ❑ No red meat ❑ No pork ❑ No eggs ❑ No poultry
❑ No seafood ❑ No dairy products ❑ Other ______________________________

(Over)

Medications: List **All** medications (*include over the counter/nonprescription*) taken routinely. Bring enough medication for entire camp in original bottle/packaging that identifies prescribing physician (*if prescription*), name of medication, dosage, and frequency. Medications dispensed according to label instructions. If the camper is not taking medication as indicated on the label, get the medication into a container properly labeled by a physician or pharmacist for current dosage. Campers are not allowed to self-medicate, except by necessity (*i.e. inhalers and the like*).

❑ This person takes **NO** medications on a regular basis. ❑ This person **takes** medications on a regular basis (*include over the counter medications*)

Medication Name_______________________ Dosage_______________________ Taken daily ❑ Yes ❑ No

Reason taking_______________________ Date started___________

Medication Name_______________________ Dosage_______________________ Taken daily ❑ Yes ❑ No

Reason taking_______________________ Date started___________

Medication Name_______________________ Dosage_______________________ Taken daily ❑ Yes ❑ No

Reason taking_______________________ Date started___________

Medication Name_______________________ Dosage_______________________ Taken daily ❑ Yes ❑ No

Reason taking_______________________ Date started___________

- - - List any additional medications on a separate sheet. - - -

Ongoing Health Concerns: Check all that pertain to this individual, and provide information about supportive healthcare.

- ❑ This individual has no ongoing health concerns
- ❑ This individual has the following ongoing health concerns
  - ❑ Asthma ❑ Headaches ❑ Sleepwalking ❑ Diabetes ❑ Frequent ear infections
  - ❑ Bedwetting ❑ Pregnancy ❑ Menstrual cramps or related concerns ❑ Other_______________________

Provide information about supportive health care for each checked item_______________________

____

If your child receives care/ medication for emotional, learning and/or psychological concerns, provide background information to help us work with this camper_______________________

____

Person completing this form_______________________ Date_______________________

Parent Initials

_____ I authorize an adult, in whose care the minor has been entrusted, to consent to X-ray examination, anesthetic, medical, surgical or dental diagnosis and treatment or hospital care for the above named minor. Such care is to be rendered under the general or specific supervision and on the advice of any physician or dentist licensed under the provisions of the Medical Practice Statutes of the State of Wisconsin, if there is insufficient time or inability to contact me. I will be liable and agree to pay all costs and expenses incurred in connection with such medical and dental services rendered pursuant to this authorization.

_____ I give permission for this minor to ride in any vehicle designated by the adult in whose care the minor has been entrusted.

_____ I will take no civil action against CrossWoods, Inc., any associated agencies, or persons in whose care the minor has been entrusted, for normal care of the minor in their charge.

_____ I give permission for this minor to receive non-prescription medications for non-emergency situations from a designated health-care provider.

_____ If my child has a headache, I usually give them _______________________ *(example: Tylenol, Ibuprofen, etc…)*

Signature of Parent / Legal Guardian _______________________ Date _______________________