Wisconsin Department of Agriculture, Trade and Consumer Protection
Division of Food and Recreational Safety
PO Box 8911, Madison, WI 53708-8911
Phone: (608) 224-4720 Fax (608) 224-4710

CAMPER HEALTH HISTORY RECORD

Wis. Admin. Code ch. ATCP 78

PLEASE PRINT

CAMPER'S PERSONAL INFORMATION (please print)

CAMPER'S NAME (Last, First, Middle Initial)	BIRTHDATE (Mo/Day/Yr.)	SEX	TELEPHONE NUMBER (Home)
, ,	/ /		( ) -

MAILING ADDRESS STREET	CITY	STATE	ZIP

NAME OF PARENT/GUARDIAN/LEGAL CUSTODIAN	WORK TELEPHONE NUMBER	CELL PHONE NUMBER
	( ) -	( ) -
NAME OF PARENT/GUARDIAN/LEGAL CUSTODIAN	WORK TELEPHONE NUMBER	CELL PHONE NUMBER
	( ) -	( ) -

CAMPER'S HEALTH CARE PROVIDER INFORMATION

HEALTH CARE PROVIDER NAME			
MEDICAL FACILITY NAME			TELEPHONE NUMBER ( ) -
MEDICAL FACILITY STREET ADDRESS	CITY	STATE	ZIP

ALLERGIES

☐ This camper has no known allergies

☐ THIS CAMPER IS ALLERGIC TO THIS FOOD(S):	DOES THIS ALLERGY CAUSE ANAPHYLAXIS? ☐ YES ☐ NO	DATE OF MOST RECENT EPISODE?	FREQUENCY OF EPISODE?	DESCRIBE REACTION AND HOW IT IS MANAGED?
☐ THIS CAMPER IS ALLERGIC TO THIS MEDICATION(S):	DOES THIS ALLERGY CAUSE ANAPHYLAXIS? ☐ YES ☐ NO	DATE OF MOST RECENT EPISODE?	FREQUENCY OF EPISODE?	DESCRIBE REACTION AND HOW IT IS MANAGED?
☐ THIS CAMPER IS ALLERGIC TO THE FOLLOWING:	DOES THIS ALLERGY CAUSE ANAPHYLAXIS? ☐ YES ☐ NO	DATE OF MOST RECENT EPISODE?	FREQUENCY OF EPISODE?	DESCRIBE REACTION AND HOW IT IS MANAGED?

MEDICATION

☐ This camper **will NOT** take any medications while attending camp.

☐ This camper **will** take the following medication(s) while attending camp. I am bringing enough medication to last the entire session and it is in the original container labeled by the pharmacy.

Medication or Treatment	Dose	When do you give it at home?	Reason for taking medication

PLEASE CONTINUE ON REVERSE SIDE

ASTHMA

☐ This camper **does NOT** have asthma. ☐ This camper **does** have asthma.

Asthma Triggers (check all that apply)		Signs/Symptoms of asthma episode	Frequency of episodes	How episode is managed
☐ Exercise	☐ Colds			
☐ Infections	☐ Emotions			
☐ Allergies (to what?)				
☐ Weather (what type?)				
☐ Other (list)				

IMMUNIZATIONS

List the MONTH, DAY, AND YEAR your child received each of the following immunizations. DO NOT USE **(√)** OR **(X)** except to answer the question about chickenpox, Tdap or Td. If you do not have an immunization record for this child at home, contact your doctor or public health department to obtain it. A copy of the child's complete immunization record from the WIR may be attached to this form (www.dhfswir.org).

TYPE OF VACCINE*	FIRST DOSE Mo/Day/Yr	SECOND DOSE Mo/Day/Yr	THIRD DOSE Mo/Day/Yr	FOURTH DOSE Mo/Day/Yr	FIFTH DOSE Mo/Day/Yr
DTaP/DTP/DT/Td (Diphtheria, Tetanus, Pertussis)					
Adolescent booster (Check appropriate box) ☐ Tdap* ☐ Td					
Polio					
Hepatitis B					
MMR (Measles, Mumps, Rubella)					
Meningococcal Conjugate Vaccine (MCV)*					
Hepatitis A					
Varicella (Chickenpox) Vaccine – Vaccine is needed only if your child has not had Chickenpox disease. See below:					
Has your child had Varicella (chickenpox) disease? Please check appropriate box and provide the date (if known): ☐ YES (please list month/year): _____/ ☐ NO or Unsure (Vaccine recommended)					
Influenza (date of most recent dose): _____/					

*These vaccines are routinely recommended at age 11-12 years.

☐ For health reasons, this child is not fully immunized.

☐ For personal conviction or religious reasons, this child is not fully immunized.

LIST VACCINE(S) NOT RECEIVED:

OTHER MEDICAL CONDITIONS

PLEASE INDICATE ANY OTHER IMPORTANT MEDICAL CONDITIONS (eg. diabetes, seizures, physical conditions, etc.)

SIGNATURE

The information included on this form is complete and accurate to the best of my knowledge.

SIGNATURE – Parent/Guardian/Legal Custodian	DATE

Personal information you provide may be used for purposes other than that for which it was originally collected. Wis. Stat. § 15.04(1)(m)