CRAZZY'S WASEWAGAN CAMP & RETREAT
HEALTH HISTORY

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Health history must be filled out by parents/guardians of minors. An updated form is required annually.

PLEASE ATTACH MOST RECENT PHOTO

Session:___________ Week:___________

Complete and sign by Parent/Guardian

Child's Name ____
Last First Initial

Birth Date ________________________ ☐ Male ☐ Female Age ______________

Parent or Guardian ____

Cell ________________________ Emergency ________________________ Email ________________________
Area/ Number Area/ Number

Home/Mailing Address ____
Street and Number City State/ ZIP

Second Parent/Guardian or Emergency Contact ____

Cell ________________________ Emergency Phone ________________________
Area/ Number Area/ Number

If not available in an emergency, please notify: ____

Phone ________________________ Relationship ________________________

Has/does your child have/had any of the following:

☐ Frequent ear infections ☐ Bedwetting ☐ Convulsions ☐ Diabetes ☐ Head injury

☐ Frequent headaches ☐ Hypertension ☐ Mononucleosis ☐ Asthma ☐ Wear glasses/contacts

☐ Sleepwalking ☐ Eating Disorder ☐ Heart Defect/disease ☐ Bipolar ☐ Orthodontic appliance

☐ Epilepsy ☐ Depression ☐ Bleeding/Clotting disorders

Please explain any 'yes' answers ____

____

Any physical or mental limitations or conditions? Yes / No - If yes, please explain ________________________
Name of family physician ________________________ Phone ________________________
Name of family dentist / orthodontist ________________________ Phone ________________________
Date of last physical examine? (mm/dd/yy). Recommended within the last 12 months ________________________

Insurance Information - Participant must be covered by family medical/hospital insurance.
Indicate carrier/plan name ________________________ Group ________________________
Photocopy of front and back of health insurance card must be attached to this form.

IMPORTANT – THIS BOXES MUST BE COMPLETED FOR ATTENDANCE

HEALTHCARE ACCEPTANCE/ REFUSAL

WAIVER ACCEPTING PERMISSION-TO-TREAT ☐ Yes ☐ No - If no, please explain ________________

____

This health history is correct and complete to the best of my knowledge. I hereby give permission to Wasewagan to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to Wasewagan to arrange necessary related transportation. In the event that I cannot be reached in an emergency, I hereby give permission to Wasewagan to the physician selected by Wasewagan to secure and administer treatment, including hospitalization, for the person named above at my expense.

Signature of Parent/Legal Guardian or Adult Camper ____

Printed Name ____ **Date** __________________________________

42121 Seven Oaks Road, Angelus Oaks 92305 ~ 805-498-5572 fax 805-498-5578

Over ➔

CRAZZY'S WASEWAGAN CAMP & RETREAT HEALTH HISTORY

Complete and sign by Licensed Physician

Child's Name ___________________________________ DOB _______________________________
MM/DD/YY

I have examined the above camp applicant. Date Examined: _________________________________

Dose the child have any physical or mental limitations or concerns? If yes, please explain__________

____

Please give all dates of immunization for:

Vaccines	Date – MM/YY					
DTP	_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)	_____	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____	_____
MMR	_____	_____	_____	_____	_____	_____
Or Measles	_____	_____	_____	_____	_____	_____
Or Mumps	_____	_____	_____	_____	_____	_____
Or Rubella	_____	_____	_____	_____	_____	_____
Haemophilus Influ B	_____	_____	_____	_____	_____	_____
Hepatitis B	_____	_____	_____	_____	_____	_____
Varicella (chicken pox)	_____	_____	_____	_____	_____	_____

Which of the following has the participant had?

- ☐ Chicken pox _____
- ☐ Measles ______
- ☐ German Measles ____
- ☐ Mumps _____
- ☐ Hepatitis A _____
- ☐ Hepatitis B _____
- ☐ Hepatitis C _____

The child is under the care of a physician for the following conditions ____

Operations or serious injuries (dates) ____

Chronic or recurring illness or medical condition ____

Medications ____

Dietary restrictions ____

Allergies (medication, food, plants, insects etc) ____

An updated Tetanus shot is required. Date of last Tetanus ____

Licensed Physician's Signature ___________________________________ Phone #________________________
Area/Number

Address____
Number and Street City State/ ZIP

Date of Form Completion _______________________

Over ➔

CRAZZY'S WASEWAGAN CAMP & RETREAT
OVER-THE-COUNTER MEDICATION RELEASE FORM

CHILD'S NAME ____ AGE: ______________
WEIGHT ______________ SESSION ______________ WEEK ______________

Parent Name ______________________________ Phone # _____________________

Emergency Contact ____________________________ Phone # ___________________

Allergies (medications, food, plants etc.) ____
Dietary Restrictions ____
Can Child Swim - Yes / No ____

Is Child Taking Prescription Medication While At Camp? Yes___ No___ If yes, please list all medications on the backside of this form.

PRESCRIPTION MEDICATION INFORMATION - PLEASE READ CAREFULLY!

All portions must be completed and clearly filled out for both non-prescription and prescription medication. All medication will be dispensed from the camp infirmary. NO MEDICATIONS OF ANY KIND WILL BE ALLOWED IN A CAMPER'S QUARTERS UNLESS ARRANGEMENTS HAVE BEEN MADE SPECIFICALLY WITH THE CAMP HEALTH DIRECTOR.

CHECK the following over-the-counter medications listed below your child may be administered while attending camp. We'll provide the following medication.

TYLENOL - Headache ☐ ADVIL - Muscle Pain ☐ BENADRYL - Allergies ☐
PEPTO-BISMOL - Upset Stomach ☐ ANT1SEPCTICS - Clean Scratches/Scrapes ☐

OTHER____

REASON COMMENTS ____

I request that Crazzy's Wasewagan Camp and Retreat see that my child is provided with medication as indicated under the following conditions:

1. I understand that ALL MEDICATION regardless whether it is over the counter or PRESCRIPTION BOTTLES MUST be turned into the Camp Infirmary upon arrival, and will only be dispensed by my written authorization.

2. I agree to release CRAZZY'S WASEWAGAN CAMP AND RETREAT, its directors, officers, agents and employees harmless from any loss, cost of expense arising in any manner from my request.

I HAVE COMPLETELY READ AND FULLY UNDERSTAND THE INFORMATION ON THIS FORM. I THEREBY RELEASE CRAZZY'S WASEWAGAN CAMP AND RETREAT STAFF MEMBERS TO DISPENSE MEDICATION, AS INSTRUCTED.
PARENTS WILL BE NOTIFIED WHEN CHILD IS GIVEN CARE BY OUTSIDE PROVIDERS.

PARENT/GUARDIAN SIGNATURE ___________________________ DATE _________

Print Name ____

Fill out backside of form only if child is taking prescription medication.

Over →

Fill Out This Side Only If Child Is Taking Prescription Medication

Crazzy's Wasewagan Camp & Retreat Prescription Release Form

CHILD'S NAME ____ AGE: _______________
WEIGHT _______________ SESSION _______________ WEEK _______________

- **ALL PRESCRRIPTION MEDICATION MUST BE IN PRESCRIBED BOTTLES AND INCLUDE DOSAGE, FREQUENCY AND REASON FOR MEDICATION.**
- IT'S YOUR RESPONSIBILTY TO PICK-UP ALL UNUSED MEDICATION. IF CHILD IS TAKING THE SHUTTLE, PLEASE ASK DRIVER FOR MEDICATION.
- UNCLAIMED MEDICATIONS ARE DISPOSED OF TWO WEEKS AFTER CHILD DEPARTS.

LIST ALL PRESCRIPTION MEDICATION BELOW - PLEASE PRINT CLEARLY!

1. MEDICATION ______________________ REASON ___________________________
DOSE __________________ FREQUENCY _________________ DAILY/AS NEEDED
COMMENTS: ____
____

2. MEDICATION ______________________ REASON ___________________________
DOSE __________________ FREQUENCY _________________ DAILY/AS NEEDED
COMMENTS: ____
____

3. MEDICATION ______________________ REASON ___________________________
DOSE __________________ FREQUENCY _________________ DAILY/AS NEEDED
COMMENTS: ____
____

4. MEDICATION ______________________ REASON ___________________________
DOSE __________________ FREQUENCY _________________ DAILY/AS NEEDED
COMMENTS: ____
____

5. MEDICATION ______________________ REASON ___________________________
DOSE __________________ FREQUENCY _________________ DAILY/AS NEEDED
COMMENTS: ____
____

I HAVE COMPLETED AND READ THE ABOVE INFORMATION. I HEARBY RELEASE CRAZZY'S WASEWAGAN CAMP AND RETREAT AND ITS STAFF MEMBERS TO DISPENCE MEDICATION, AS INSTRUCTED, AT THEIR DISCRETION.

PARENT/GUARDIAN SIGNATURE__________________________ DATE _____________