

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 Code & Number Area Code & Number

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

Second Parent/Guardian _____

Cell # _____ Emergency # _____
Area Code & Number Area Code & Number

Emergency Contact Name/Relationship: _____ Phone _____

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

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Sleepwalking | <input type="checkbox"/> Orthodontic appliance |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Bleeding/Clotting Disorder | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Defect/disease | <input type="checkbox"/> COVID-19 |
| <input type="checkbox"/> Head injury | <input type="checkbox"/> Wear glasses/contacts | <input type="checkbox"/> Bipolar | |

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 exam? (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 BOX 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** _____

CRAZZY'S WASEWAGAN CAMP & RETREAT HEALTH HISTORY

Session: _____ Week: _____

Please have this Completed and Signed by your child's Primary Care Doctor:

Child's Name _____ DOB _____
MM/DD/YY

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

Does the child have any physical or mental limitations or concerns? If yes, please explain _____

Please give all dates of immunization for:

<u>Vaccines</u>	<u>Date – MM/YY</u>					
DTP	_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)	_____	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____	_____
MMR	_____	_____	_____	_____	_____	_____
Or Measles	_____	_____	_____	_____	_____	_____
Or Mumps	_____	_____	_____	_____	_____	_____
Or Rubella	_____	_____	_____	_____	_____	_____
Haemophilus Influen 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 _____
- ☐ COVID-19 _____

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 (Frequency & Dosages) _____

Dietary restrictions _____

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

COVID-19 Vaccine Date: (Recommended):
_____ 1st Dose _____ 2nd Dose _____ Booster _____ Booster _____

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

Licensed Physician's Signature _____ Date: _____

Physician and/or Practice Name: _____

Address _____
Number and Street City State/ ZIP

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

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

Session: _____ Week: _____

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 or Over the Counter Medication from Home While At Camp? Yes___ No___

If yes, please list all medications including frequency and dosages on the next page.

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 Crazy'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 _____

**Fill Out This Page If Child Is Taking Prescription Medication or Over the Counter
Medication from Home**

Crazy's Wasewagan Camp & Retreat Medication Release Form

CHILD'S NAME _____ AGE: _____

WEIGHT _____ SESSION _____ WEEK _____

Parent Name _____ Phone # _____

**ALL MEDICATION MUST BE IN PRESCRIBED OR ORIGINAL OTC BOTTLES WITH CHILD'S
NAME AND INCLUDE DOSAGE, FREQUENCY AND REASON FOR MEDICATION.**

IT'S YOUR RESPONSIBILITY 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 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 DISPENSE MEDICATION, AS
INSTRUCTED, AT THEIR DISCRETION.**

PARENT/GUARDIAN SIGNATURE _____ DATE _____