UNIVERSITY OF WISCONSIN- MADISON

SUMMER YOUTH CAMP HEALTH HISTORY RECORD

INSTRUCTIONS TO PARENT: COMPLETE AND RETURN TO THE CAMP. Contact your child's health care provider or camp Director if you need assistance completing this form.

NAME OF CAMP ATTENDING: Korean Language & Culture Academy

CHILD'S Personal Information

Name - Child's (Last, First, Middle Initial)	Birthdate (Mo/Day/Yr)	Telephone Number (Home) ( )
Address (Street, City, State, Zip)		

Name of Parent/Guardian/Legal Custodian	Work Telephone Number ( )	Cellphone Number ( )
Name of Emergency Contact	Work Telephone Number ( )	Cellphone Number ( )

CHILD'S Health Care Provider

Health Care Provider Name	Name of Clinic:
Address of Facility (Street, City, State, Zip)	Telephone Number ( )

ALLERGIES

Please check all that apply:

This child has no known allergies.	This child is allergic to this **food(s):**	This child is allergic to this **medication(s)**:	This child is allergic to the following: _____
	Does this allergy cause anaphylaxis? Yes No	Does this allergy cause anaphylaxis? Yes No	Does this allergy cause anaphylaxis? Yes No
	Date of most recent episode?	Date of most recent episode?	Date of most recent episode?
	Describe reaction and how it is managed?	Describe reaction and how it is managed?	Describe reaction and how it is managed?

MEDICAL CONDITIONS

Please check all that apply:

ASTHMA	This child does **NOT** have asthma.	This child does have asthma and has completed action plan attached.
DIABETES	This child does **NOT** have diabetes.	This child does have diabetes and has diabetes management plan attached

MENTAL HEALTH CONCERNS

This child does **NOT** have any mental health concerns.	This child has the following mental health concerns: ADD/ADHD Anxiety Autism Spectrum Disorders Bipolar Depression Eating Disorder Self-Injurious Behavior Other: _____ Are they currently receiving mental health services? YES NO

MEDICATION

This child **will NOT** take any daily medications while attending camp.

Camp health staff may administer over-the-counter medications as needed.

This child **will** take the following medication (includes vitamins, supplements, and over-the-counter) while attending camp.

- I am bringing enough medication to last the entire session
- All medications **MUST** be in the original labeled container and if prescription is labeled by the pharmacy.

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

OTHER HEALTH CONCERNS

Please indicate any other important medical conditions (e.g. 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 Signed