Health History Questionnaire

for Athletic Summer Camps/Programs

Completion of both sides of form is REQUIRED prior to participation

CAMP EVENT: _____

CAMP DATES: _____

Participant: _____
Last First MI

Date of Birth: ____/____/____ Sex: ❑ Female ❑ Male Height: _____ Weight: _____
M D Y

Home Address: _____

City: _____ State: _____ Zip: _____

Home Telephone Number: _____

Has participant had or is presently experiencing: *(Please check ✓ all that apply)*

Yes	No		Yes	No		Yes	No	
❑	❑	Allergies	❑	❑	Epilepsy/Seizures/Blackouts	❑	❑	Menstrual Difficulties
❑	❑	Asthma	❑	❑	Heart Disease	❑	❑	Mental/Emotional Problems
❑	❑	Bleeding Disorder	❑	❑	Hernia	❑	❑	Neck/Back Pain/Injury
❑	❑	Cancer	❑	❑	High Blood Pressure	❑	❑	Rheumatic Fever
❑	❑	Colitis	❑	❑	Joint Injury/Surgery	❑	❑	Tuberculosis
❑	❑	Diabetes	❑	❑	Kidney Disease	❑	❑	Ulcer

Does participant take medication on a regular basis? ❑ Yes ❑ No If yes, identify_____
(Consent for medication administration must be signed on reverse side)

Does participant have allergic reactions to:

Yes	No		Yes	No	
❑	❑	Penicillin	❑	❑	Other Antibiotics _____
❑	❑	Other Medicine (type) _____	❑	❑	Insect Bites/Stings _____

Immunization Record

MMR *(measles, mumps, rubella)*

* Dose 1 - given at age 12-15 months or later ____/____/____ (M D Y)

* Dose 2 - given at age 4-6 years or later ____/____/____ (M D Y) and at least 4 weeks after first dose.

Tetanus-Diptheria *(initial series completed)* ____/____/____ (M D Y)

Year of last tetanus booster (Preferably within last 10 years) ____/____/____ (M D Y)

Has participant ever had major surgery or been hospitalized? ❑ Yes ❑ No If yes, explain:_____

_____

Please explain any significant operations, accidents or illnesses, and last medical attention and reason:_____

_____

_____

Does the participant have any physical condition(s) requiring special considerations? Explain.

_____

_____

A physical examination within 24 months of the camp/event is recommended. Date of participant's last physical examination:

_____

TRI-STATE CAMPS | 605 S Randolph St | Cuba City, WI 53807 | (608)744-2585 | FAX (608)744-7389 | tristate@mhtc.net | tristatecamps.com

Medical Treatment and Medication Administration Consent Form

Completion of both sides of form is REQUIRED prior to participation

Participant: _____

Parent/Guardian: _____

Home Telephone: _____ Work Telephone: _____

Name of Physician: _____ Telephone: _____

Name of Insurance: _____ Policy #: _____

Alternative contact in the event that the Parent/Guardian cannot be contacted in the case of an emergency (injury/illness) involving the participant named above.

Name: _____ Relationship: _____ Telephone: _____

If your son, daughter or ward will be under the age of 18 years while at Tri-State Camps, it is policy to secure your consent for medical treatment and medication distribution, whether medication/treatment is self-administered or administered by designated camp staff.

All medication must be in *original or seperate medicine bottles and labeled with the camper's name.* Prescription medication(s) must also include on the label *doctor's name and phone number, medication name and dosage.*

❑ **No** medication brought to camp.

❑ **Yes**, non-presecription/over the counter medications are being brought to camp. Non-prescription/over the counter medication can be self-administered. Please indicate the name of the medication(s), dosage, and reason for taking the medication:

_____

_____

If camper is **NOT** allowed to self-administer non-prescription/over the counter medications, sign here:

_____

❑ **Yes,** prescription medication(s) and/or medical device(s) are brought to camp. *Complete medication box below.*

❑ **Yes,** I will self-administer the medication(s) and/or medical device(s). ***This is allowed if 14 years old or older.***

❑ Designated camp staff, i.e. nurse, athletic trainer, camp counselor, will administer the medication(s) and/or medical device(s). ***Mandatory for age 13 and under.***
*** However, a limited amount of medication for life threatening conditions may be carried by my son/daughter/ward, i.e. allergy medications, bee sting kits, inhalers, insulin.*

Name of Medication and prescribing MD	Dosage	How is it taken, i.e. oral, injection	Time(s) of day medication is taken	Day(s)/Number of days medication is to be taken

Special Instructions: _____

_____

_____

_____

_____

By signing below, you are:

- Acknowledging that you have received the notice of Privacy Practices statement.
- Giving your consent in advance for medical treatment at an appropriate medical facility in case of illness or injury.
- Stating that you are aware of and accept the risk inherent in program activity.
- Agreeing to hold harmless and indemnify the Tri-State Basketball Camp staff, their officers, agents and employees, from any and all liability, loss, damages, costs or expenses which are sustained, incurred, or required arising out of the actions of your dependent in the course of the camp/event.

Signature: _____ **Date:** _____

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