University of Wisconsin-Parkside
PART ONE:
CONSENT FOR MEDICATION ADMINISTRATION
and MEDICAL TREATMENT

TO THE PARENT(S) OR LEGAL GUARDIAN:
If your son, daughter, or ward will be under the age of 18 while at the University of Wisconsin-Parkside, it is policy to secure your consent for medication distribution and for the use of medical devices. The medication or medical device can be self-administered or be administered by the Camp Health Supervisor.

All medications must be in a medicine bottle and labeled with the camper's name, doctor's name and phone number, medication name, and dosage. You must also complete the form below:

_____ No medication has been brought to camp.

_____ I want the medication or medical devices self-administered. (Age 14 and above only.)

_____ I want the medication or medical device administered by the Camp Health Supervisor. However, a limited amount of medication for life threatening conditions may be carried by my son/daughter/ward. (i.e., bee sting kits, inhalers)

_____ _____ _____
Name of Medication | Prescribing Doctor | Doctor's Phone #

_____ _____ _____
Amount to be taken | How is it taken | When to be administered

_____ _____
Day(s) to be taken | Special Instructions

- If your son, daughter, or ward will be under the age of 18 years while at our camp, it is our policy to secure your consent for medical treatment.
- By signing below you are giving your consent in advance for medical treatment at an appropriate medical facility in case of illness or injury.
- By signing below you are stating that you are aware of and accept the risk inherent in the program activity.
- By signing below you agree to hold harmless and indemnify the Board of Regents of the University of Wisconsin System, and the University of Wisconsin-Parkside, their officers, employees and agents, from any and all liability, loss

_____
Participant Name (Please Print)

_____ _____
Signature of Parent or Guardian | Date

PART TWO: HEALTH HISTORY QUESTIONNAIRE

Full Participant Name:

Name of Camp/Event: Camp Dates:

Full Home Address:

Home Telephone Number:

Date of Birth: ____/____/____ Sex: M F

Height: Weight:

Parent/Guardian Name:

Relationship:

Address (if different than above)

Home Telephone Number: (if different than above)

Parent/Guardian Work Telephone:

Does participant have allergic reactions to:
❑ Yes ❑No…….Penicillin
❑ Yes ❑No…….Other Antibiotics _____
❑ Yes ❑No…….Other Medicine (type) _____
❑ Yes ❑No…….Insect Bites/Stings _____

Alternate contract in the event that the Parent/Guardian cannot be contacted during an injury of illness. (Name, Relationship, Address, and Telephone Number)

Physician: _____ Telephone: _____

Insurance Co.:_____ Policy No.: _____

Does participant take medication on a regular basis?
❑ Yes ❑No If yes, Identify _____
(consent for medication administration must be signed on reverse)

Immunization Record

*MMR (measles, mumps, rubella)
Dose 1-Immunization at age 1 ❑ Yes ❑No

Dose 2 ❑ Yes ❑No

* Tetanus-Diphtheria ❑ Yes ❑No

* Year of last tetanus Boost
(must be within last 10 years)

Has participant ever had major surgery or been hospitalized? ❑ Yes ❑No

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: _____

Has participant had or presently experiencing:

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