

# HEALTH HISTORY

Sky Lodge Christian Camp ♦ N4855 County Road Y ♦ Montello, WI 53949  
 Phone: 608-297-2566 ♦ Fax: 608-297-7080 ♦ E-mail: [register@skylodge.org](mailto:register@skylodge.org) ♦ Web Site: [www.skylodge.org](http://www.skylodge.org)

**To be completed by Parent or Guardian every year.**

Name \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_

Age \_\_\_\_\_ Grade in Fall \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

**Session Attending:**     **Junior Camp**     **Young Teen Camp**     **The Zone**     **Cowgirl or Equestrian Camp**

Personal History (Give approximate age at which these conditions occurred.)

Allergies _____	Kidney trouble _____	Rheumatic Fever _____
Appendicitis _____	Measles; regular _____	Venereal disease _____
Asthma _____	Measles; German _____	Seizures _____
Chicken Pox _____	Scarlet fever _____	Tonsillitis _____
Mumps _____	Whooping cough _____	Tuberculosis _____
Heart trouble _____	Muscle or _____	Diabetes _____
Hearing problem _____	nerve disorder _____	Other _____
	Pneumonia _____	_____
		_____

Allergies to any medications \_\_\_\_\_

Other allergies \_\_\_\_\_

Operations or injuries \_\_\_\_\_

History of emotional or behavioral disturbance \_\_\_\_\_

Special conditions to be watched for, such as bed wetting, fainting, sleep walking, etc. \_\_\_\_\_

List the kind and purpose of all medications camper is bringing with him/her. \_\_\_\_\_

Has girl been told about menstruation?     Yes     No                      Has girl menstruated?     Yes     No

The Camp Health Supervisor will be dispensing over the counter drugs (such as Tylenol, cough drops) if needed. Are there any over the counter drugs that your child should not receive? \_\_\_\_\_

Name of Health Insurance Company \_\_\_\_\_

Policy # \_\_\_\_\_ Name of Insured \_\_\_\_\_

Immunization Record	DPT	Adult Tetanus	Polio	MMR	Hib	Hep b	Varicella (chicken pox)	Other
Date of initial immunization completed								
Date of most recent booster								

In an emergency, I hereby give permission to the licensed physician selected by Sky Lodge Christian Camp to hospitalize, secure proper treatment, anesthesia, or surgery for my child named on the form. I also consent to routine non-surgical medical care.

Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Another emergency contact name and phone \_\_\_\_\_