HEALTH HISTORY

Sky Lodge Christian Camp ◆ N4855 County Road Y ◆ Montello, WI 53949
Phone: 608-297-2566 ◆ Fax: 608-297-7080 ◆ E-mail: skylodgecamp@gmail.com ◆ Web Site: www.skylodge.org

To be completed by Parent or Guardian every year.

Name _____ Sex _____ Date of Birth_____

Age _____ Grade in Fall '24 _____ Weight _____ Height _____

Session(s) Attending: □Young Teen Camp □Junior Camp
□Equestrian Camp 1 □Equestrian Camp 2 □Equestrian Camp 3 □Equestrian Camp 4 □Cowgirl 1 □Cowgirl 2
□Adventure Camp □Guy Stuff Camp

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

Allergies _____
Appendicitis _____
Asthma _____
Chicken Pox _____
Mumps _____
Heart trouble _____
Hearing problem _____

Kidney trouble _____
Measles; regular _____
Measles; German _____
Scarlet fever _____
Whooping cough _____
Muscle or
nerve disorder _____
Pneumonia _____

Rheumatic Fever _____
Venereal disease _____
Seizures _____
Tonsillitis _____
Tuberculosis _____
Diabetes _____
Other _____

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 _____

Fill in immunizations—or attach print out

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 _____ Mom's cell _____ Dad's cell _____

Address _____ City _____ State _____ Zip_____

Another emergency contact name and phone _____