L1915, March 1999, (608)785-6800. Personally identifiable information will not be used for secondary purposes.

University of Wisconsin-La Crosse Health History Questionnaire

PARTICIPANT:____ ______-____-________
Last First M.I. SOCIAL SECURITY #

HOME ADDRESS:____ _____ _________
Street City State Zip

Parent/Guardian:____________________________________ Relationship:___________________

HOME PHONE: (_______) _______ - _____________ WORK PHONE: (_______) _______ - ____________

Address if different from above:_____________________________________ ___ ______
Street City State Zip

In case of an emergency (injury or illness), if you are unable to be contacted whom shall be contacted:

Name:__________________________________ Relationship__________ Phone:______________

Name of Physician:____ Phone:______________

Name of Insurance Co.:____ Policy #_____________

CAMP/EVENT ___________________________ CAMP DATES _________________

DATE OF BIRTH ____/____/____ Sex: _____ F ____ M

Height ____________________ Weight ____________

Does participant have allergic reactions to:

YES	NO	IDENTIFY
☐	☐	Penicillin
☐	☐	Other Antibiotics _________________
☐	☐	Other Medicines (type) ____________
☐	☐	Insect Bites/Stings ________________

Are you taking any medication regular ____ YES ____ NO

If YES, Identify ________________________________

(Consent for Medication Administration must be signed.)

Immunization Record:

* MMR (measles, mumps, rubella)

Dose 1-Immunization at 12 months or after _____/_____/_____

Dose 2 _____/_____/_____

*Tetanus-Diphtheria

*Year of initial series completed _____/_____/_____

*Year of last tetanus booster _____/_____/_____
(must be within last 10 years)

Have you 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.

____

____

Participant must have had a physical examination within 36 months of the camp/event participant is registering for in order to participate. Please furnish date of the last physical examination. _____/_____/_____

Has participant had or presently experiencing:

YES	NO		YES	NO	
☐	☐	Allergies	☐	☐	High Blood Pressure
☐	☐	Asthma	☐	☐	Joint Injury/Surgery
☐	☐	Bleeding Disorder	☐	☐	Kidney Disease
☐	☐	Cancer	☐	☐	Menstrual Difficulties
☐	☐	Colitis	☐	☐	Mental/Emotional Problem
☐	☐	Diabetes			
☐	☐	Blackouts	☐	☐	Back Pain or Injury
☐	☐	Seizures	☐	☐	Neck Pain or Injury
☐	☐	Epilepsy	☐	☐	Rhuematic Fever
☐	☐	Heart Disease	☐	☐	Tuberculosis
☐	☐	Hernia	☐	☐	Ulcer

Other:____

MUST COMPLETE Camps and Clinics Consent for Medication/Consent for Medical Treatment Form and submit with this document.