House In The Wood *Operated by Northwestern Settlement, Chicago, IL*
3300 Bay Rd | Delavan, WI 53115 | 262-728-2752 | info@houseinthewood.org

northwestern settlement

Outdoor Education Health History and Scholar Info

Classroom: ______Scholar: ______________________________Birthdate: ______________
Parent/guardian 1: ______________________________Relationship: ____________Phone: ______________
Parent/guardian 2: ______________________________Relationship: ____________Phone: ______________
Address: ____
City, State: ______________________________Zip Code: ______________
Emergency Contact 1: ______________________________Relationship: ____________Phone: ______________
Emergency Contact 2: ______________________________Relationship: ____________Phone: ______________

Doctor/Care Provider 1: ______________________________Phone: ______________
Doctor/Care Provider 2: ______________________________Phone: ______________
Coverage Agency/ID Number: ____

Check if Scholar has:	Medication	Notes, Treatments, Details
❑ history of hospitalization or surgeries	❑	type/date:
❑ chronic condition or recent infectious disease	❑	
❑ history of seizures	❑	
❑ frequent ear infections	❑	
❑ history of head lice	❑	
❑ history of headaches	❑	
❑ history of problems sleeping/sleepwalking/ bedwetting	❑	
❑ vision problems	❑	❑ glasses ❑ contacts
❑ hearing problems	❑	hearing device: ❑ right ❑ left
❑ allergies	❑	
❑ skin problems	❑	
❑ menstrual problems	❑	
❑ problems with diarrhea or constipation	❑	
❑ joint/back problems	❑	
❑ diabetes	❑	
❑ other physical, emotional, or psychiatric condition	❑	

Allergies: ❑ No known allergies ❑ Food allergies ❑ Environmental allergies (pollen, insects, etc.) ❑ Other
(Please use this space to describe allergies, reactions and treatments.)

Asthma: ❑ No asthma ❑ Has asthma ❑ Inhaler ❑ Nebulizer ❑ Oral Medications (Singulair, Prednisone, etc.) **All asthma medication must be brought to camp** even if rarely used. Camp has its own nebulizer, so only send the medication and one complete setup; **do not send the nebulizer** itself.

Diet/Nutrition: ❑ Regular diet ❑ Regular vegetarian diet ❑ Special food needs (describe below)

Restrictions: ❑ Participate fully without restrictions ❑ Participate with following restrictions:

Health Plan – Please provide a health plan for any chronic conditions.

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Medication	Condition	Dose (Amount, frequency, times)	Rx or OTC

Rx = Prescription, OTC = Over the counter

The following over the counter medications are kept in our health center and used per protocols signed by our MD to manage illness or injury. **Indicate any medications that SHOULD NOT be given:**

Pain Relief
Acetaminophen (Tylenol)
Ibuprofen (Advil, Motrin)

Allergy
Loratidine (Claritin)
Fexofenadine (Allegra)
Diphenhydramine (Benadryl) Tablets

Wound Care
Antibiotic Ointment

Cough and Cold
Guaifenesin for cough (Mucinex)
Robitussin (or generic) Cough Syrup
Cough drops/sore throat spray

Indigestion/Stomach Upset
Pepcid Tablets
Antacid (Maalox, etc.)
Tums

Ringworm/Athletes Foot
Lotrimin (or equivalent

Rashes, Bites, and Itching
Diphenhydramine (Benadryl) Spray
Hydrocortisone 1% cream
Diphenhydramine (Benadryl) Cream
Calamine lotion
Aloe

Misc.
Insect Repellent (13% DEET)
Sunscreen 15SPF+ (or higher)
Lice shampoo/scabies (Nix/Elimite)

Mental, Emotional and Social Health Check if the scholar has

- ❑ Been treated for ADD or AD/HD
- ❑ Been treated for any emotional or behavioral difficulties or an eating disorder
- ❑ Seen a professional due to mental/emotional health concerns in the past 12 months
- ❑ Had a significant life event that continues to effect the scholar's life (new sibling, family change, death in family, abuse, etc.)

Explain any checked boxes:

- **If your child is ill prior to camp, please contact us to ensure that he/she will be able to attend.**
- Please do not send over the counter medications with your child. We will provide them as needed.

This health history is correct and accurately reflects the health status of the scholar to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Parent/Guardian: ______________________________

Date: ____________________ Relationship to Child: ______________________________