



Part Two: SPORT CAMP HEALTH HISTORY QUESTIONNAIRE

Please indicate any other sport camp you are attending at UWM with the dates. We will transfer your medical records to the other camp.

- | | |
|--|---|
| <input type="checkbox"/> Girls Basketball _____
<input type="checkbox"/> Boys Basketball _____
<input type="checkbox"/> Volleyball _____
<input type="checkbox"/> Track _____ | <input type="checkbox"/> Girls Soccer _____
<input type="checkbox"/> Boys Soccer _____
<input type="checkbox"/> Baseball _____
<input type="checkbox"/> Tennis _____ |
|--|---|

Participant: _____ <small style="display: flex; justify-content: space-between; width: 100%;"> Last First Middle Initial </small> Home Address: _____ <small style="display: flex; justify-content: space-between; width: 100%;"> Street City State Zip </small>	Camp/Event: _____ Camp Dates: _____ Sex: <input type="checkbox"/> F <input type="checkbox"/> M Date of Birth: _____ Height: _____ Weight: _____																		
Parent/Guardian: _____ Relationship: _____ Home Phone: _____ Work Phone: _____ <small style="display: flex; justify-content: space-between; width: 100%;"> Area Code + Number Area Code + Number </small> Address (if different from above): _____ <small style="display: flex; justify-content: space-between; width: 100%;"> Street City State Zip </small>	Does participant have allergic reactions to: <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; width: 10%;">YES</th> <th style="text-align: left; width: 10%;">NO</th> <th style="text-align: left; width: 80%;">IDENTIFY</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Penicillin _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Other Antibiotics _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Other Medicines _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Insect Bites/Stings _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Foods _____</td> </tr> </tbody> </table>	YES	NO	IDENTIFY	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin _____	<input type="checkbox"/>	<input type="checkbox"/>	Other Antibiotics _____	<input type="checkbox"/>	<input type="checkbox"/>	Other Medicines _____	<input type="checkbox"/>	<input type="checkbox"/>	Insect Bites/Stings _____	<input type="checkbox"/>	<input type="checkbox"/>	Foods _____
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In case of an emergency or illness, if you are unable to be contacted, whom shall we notify: Name: _____ Relationship: _____ Address: _____ Phone: _____ <small style="display: flex; justify-content: space-between; width: 100%;"> Street City State Zip Area Code + Number </small> Name of Physician: _____ Phone: _____ <small style="display: flex; justify-content: space-between; width: 100%;"> Area Code + Number </small> Name of Insurance Co.: _____ Policy #: _____	Is the participant taking any medication(s) regularly? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, identify medication: _____ <small style="text-align: center;">(Consent for Medication Administration Must Also Be Signed)</small>																		

Immunization Record:		Has the participant ever suffered from, or are they currently experiencing, any of the following:																																																													
•	MMR (Measles, Mumps, Rubella)	Dose 1 - Immunization at 1 yr. <input type="checkbox"/> YES <input type="checkbox"/> NO																																																													
		Dose 2 <input type="checkbox"/> YES <input type="checkbox"/> NO																																																													
•	Tetanus-Diphtheria	<input type="checkbox"/> YES <input type="checkbox"/> NO																																																													
•	Year of last Tetanus Booster (must be within last 10 yrs.) _____																																																														
Has the participant ever had major surgery or been hospitalized? <input type="checkbox"/> YES <input type="checkbox"/> NO Please explain any significant operations, accidents or illnesses, and last medical attention and the reason: _____ _____ _____ _____ _____ Does the participant have any physical conditions requiring special considerations? Explain. _____ _____ _____ _____		<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; width: 10%;">YES</th> <th style="text-align: left; width: 10%;">NO</th> <th style="text-align: left; width: 40%;">Allergies</th> <th style="text-align: left; width: 10%;">YES</th> <th style="text-align: left; width: 10%;">NO</th> <th style="text-align: left; width: 10%;">High Blood Pressure</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Allergies</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>High Blood Pressure</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Asthma</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Joint Injury/ Surgery</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Bleeding Disorder</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Kidney Disease</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Cancer</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Menstrual Difficulties</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Colitis</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Mental/Emotional Problem</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Diabetes</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Neck/Back Pain Injury</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Epilepsy/Seizure Blackouts</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Rheumatic Fever</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Heart Disease</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Tuberculosis</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Hernia</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Ulcer</td> </tr> </tbody> </table>		YES	NO	Allergies	YES	NO	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Joint Injury/ Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Mental/Emotional Problem	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Neck/Back Pain Injury	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizure Blackouts	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer
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