TRIMBORN FARM – MILWAUKEE COUNTY HISTORICAL SOCIETY
2011 DAY CAMP HEALTH HISTORY/EMERGENCY CARE FORM

Please complete the following using a separate form for each camper.

Child's Name:____

Address: ____

City:____________________________________ State:___________ Zip Code:__________

Birthdate:_____/_____/_________ Age:________________ Home phone:______________

VACCINATION DATES

Hepatitis B				
MMR				
HIB				
Varicella				
DPT				
TB Test				
Other (please specify)				

PHYSICIAN OR MEDICAL FACILITY

Physician Name:____ Phone Number:______________________

Name & Address of Medical Facility: ____

ADDITIONAL HEALTH INFORMATION
Please check any of the following that apply to your child:

- ❑ No special medical conditions
- ❑ Asthma
- ❑ Seizures
- ❑ Diabetes
- ❑ Gastrointestinal or digestive disorders including special dietary needs
- ❑ Emotional or behavioral disorders including ADD/ADHD
- ❑ Physical, sensory, or cognitive disabilities
- ❑ Other (non-allergy) conditions _____________________________________

Does your child have any allergies? (please list allergy and any triggers)

What steps should camp staff follow?(If medications are required, please fill out a Medication Form)

Please provide any additional medical information that may be helpful to camp staff (attach an additional page if needed).

I hereby give my consent for emergency medical care of treatment of my child in the event I cannot be reached immediately. I understand that the Milwaukee County Historical Society, its employees, and its volunteers disclaim any and all liability for loss or injury sustained by my child before, during, or after any session or activity.

____ ____________________
Signature of parent/guardian *Date*

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CURRENT MEDICATIONS

Medication Name	*Dosage*	*Frequency*	*Condition*

PHYSICIAN

Physician Name:_____________________________________ Phone Number:______________________

Please provide any additional special instructions that may be helpful to camp staff (attach an additional page if needed).

I hereby understand that my child is responsible for self-medicating. I understand that the Milwaukee County Historical Society, its employees, and its volunteers disclaim any and all liability for loss or injury sustained by my child before, during, or after any session or activity.

____ ____________________
Signature of parent/guardian *Date*