



P.O. Box 10
361 N. Lake Shore Drive
Williams Bay, WI 53191

Lake Geneva Fresh Air Association - Holiday Home Camp
Outdoor **W**isconsin **L**eadership **S**chool
HEALTH FORM



Phone: 262-245-5161
Fax: 262-245-6518
Email:

(under 18 years old—must be signed by parent or guardian)

Participant Name _____ Birth Date _____

School or Group Name _____ Program Date(s) _____

Home Address _____ Phone _____

City _____ State _____ Zip _____

Physician _____ Phone _____

In case of emergency, notify _____ Day Phone _____

Evening Phone _____

Their relationship to you? _____ Cell Phone _____

Day Phone _____

Alternate emergency contact _____ Evening Phone _____

Phone _____

Their relationship to you? _____

It is vital to the health and safety of program participants that all medical conditions or concerns be fully disclosed on this form. It is the responsibility of the program participant/the participant's parent/guardian to assure that the following information is complete and accurate.

Medications being taken _____ Date of most recent tetanus booster _____

Do you currently have any of the following medical conditions? **Check if the answer is yes.**

Heart Condition _____ Diabetes _____ Asthma _____ Allergies _____

Pregnancy _____ If yes, participation in the program may be limited. Please call us to discuss.

Orthopedic problems (including recent sprains or breaks) _____

Please briefly explain any condition that you checked (for pregnancy, provide due date):

Please describe any other health condition(s) or use of prostheses or medical devices (i.e. hearing aids, etc.) that might affect your participation in any physical activity:

In the event I cannot be reached in an emergency, I grant permission to Lake Geneva Fresh Air Association, including Holiday Home Camp (LGFAA-HHC) to secure and administer treatment by approved physician(s) and/or health care provider(s) for necessary medical, surgical, dental or health care during the LGFAA-HHC experience.

I also understand that my signature on this form denotes permission to disclose pertinent health information to appropriate LGFAA-HHC personnel or other entities designated as having a legitimate health interest.

Signature (if under 18 years of age—must be signed by parent or guardian) _____ Date _____

Contact OWLS at (262) 245-5161 with any questions or concerns.