



323 S. 5<sup>th</sup> Avenue Sturgeon Bay, WI 54235  
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 Website: [www.sturgeonbaymoravian.org](http://www.sturgeonbaymoravian.org) and click on P.A.T.H.

### Health History and Emergency Care Plan Form

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Home Phone: \_\_\_\_\_

**Parent and Emergency Contact Information:** Please provide information for where each person may be reached during the hours the child is at Camp T/TH 10 a.m. – 2 p.m. Thank you.

**Mother:** Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Home: \_\_\_\_\_

**Father:** Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Home: \_\_\_\_\_

**Back-up Emergency Contacts: They will be called in order listed.**

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_ Phone Contact Info: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_ Phone Contact Info: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_ Phone Contact Info: \_\_\_\_\_

I give permission for P.A.T.H. Staff to apply bug repellent and sunscreen to my child as needed during outings. \_\_\_\_\_ Yes \_\_\_\_\_ No

I will take responsibility for applying bug repellent and sun screen prior to dropping my child off at camp and do not want it reapplied during outings.

\_\_\_\_\_ Yes \_\_\_\_\_ No

Parent Signature: \_\_\_\_\_ Parent Signature: \_\_\_\_\_

**Please turn over and complete other side of form.**

**Health History Information:** Please attach any health care information from your physician that you believe will be necessary information for staff to have to care for your child during camp. Check any special conditions that apply:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Asthma  | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> No special medical conditions                      |
| <input type="checkbox"/> Cerebral Palsy/Motor Disorder                             | <input type="checkbox"/> Epilepsy/Seizure Disorder | <input type="checkbox"/> Gastrointestinal or feeding concerns               |
| <input type="checkbox"/> Other conditions that require care. Please specify: _____ |  | <input type="checkbox"/> Any Cognitive Disability – Please list type: _____ |
| <input type="checkbox"/> Food Allergies/Special Diet: _____                        |  |   |
| <input type="checkbox"/> Non-Food Allergies: _____                                 |  |   |

These questions pertain to the conditions listed above.

1. Triggers that may cause problems – Specify: \_\_\_\_\_
2. Sign or Symptoms to watch for – Specify: \_\_\_\_\_
3. Steps the child care provider should follow – Specify: \_\_\_\_\_
4. **Medication Treatment:** P.A.T.H. staff will **NOT** routinely administer medication to students. If medication is required in an emergency situation then parents must complete this section of the form and provide training to staff on medication administration prior to the start of camp.

**Medication to be administered (including route and dosage):** \_\_\_\_\_

**Reason for medication use:** \_\_\_\_\_

**Directions for administering medication:** \_\_\_\_\_

**Identify by name the specific camp staff members who you have trained to provide this medication:** \_\_\_\_\_

**When to call parents regarding symptoms or failure to respond to treatment:** \_\_\_\_\_

**When to consider that the condition requires emergency treatment by calling 911:** \_\_\_\_\_

**X** Parent Signature for administration of medication by Camp Staff: \_\_\_\_\_ **Date:** \_\_\_\_\_

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician Address: \_\_\_\_\_

For Office Use Only:  Registration form complete  Reg. fee received  HH/ECP form complete

Interview Date: \_\_\_\_\_ Admitted to Camp  1  2

Signature of person reviewing all forms : \_\_\_\_\_ Date: \_\_\_\_\_