



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

Lake Geneva Fresh Air Association - Holiday Home Camp  
**O**utdoor **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.**