

**Luther Crest Bible Camp
Day Camp Health Form**

The completed forms and a check payable to Crosslake Lutheran in the amount of \$10 for each child attending should be mailed to the following by **Monday, July 19, 2010. Attention: Rene Millner, Crosslake Lutheran Church, P.O. Box 248, Crosslake, MN 56442.** A complete health history **IS** necessary, and campers **MUST** have a **signed** and **completed** health form to attend camp. A physical is required **ONLY** if there are any health problems, activity limitations, or if the camper is under doctor's care while attending camp. If the camper is required to have a physical for camp attendance, and he/she has had one within the last 12 months, then a photocopy of the signed physical must be attached to this form.

Camper Name: _____
Last First Middle Initial

Street Address: _____

City, State, Zip: _____

Gender: _____ Age: _____ Birth Date: _____ Grade Completed ('09-'10 School Year): _____

Parent Contact Information: We will call you if an emergency should arise or if we have questions about your child. Please provide contact information for others who know your child and with whom we may consult if you are not available. We will assume you have spoken with these individuals and they are willing to assist if needed

Parent/ Guardian: _____ Day Phone Number: _____

Relationship: _____ Evening Phone Number: _____ Cellular Phone Number: _____

Alternate Contact: _____ Day Phone Number: _____

Relationship: _____ Evening Phone Number: _____ Cellular Phone Number: _____

Parent/ Guardian: _____ Day Phone Number: _____

Relationship: _____ Evening Phone Number: _____ Cellular Phone Number: _____

Insurance/ Billing Information: In the event of an accident or injury requiring medical attention, your personal insurance will be considered **PRIMARY CARRIER.** Items not covered by your insurance may be referred to Luther Crest Bible Camp for secondary coverage.

Company Name: _____

Policy Number: _____

Company Address: _____

In the event the above named camper needs to see a Doctor while at camp, bill should be sent directly to:

(Please **Check one**)

- To the Parents
- To the Parents' Health Insurance Company

(Be sure above information is accurate when checking this option)

Health History: We use this information to 1) Provide health care with an informed background about your child; 2) Educate counseling staff about camper needs; 3) Brief kitchen staff about dietary needs.

Allergies: Check those which apply to this camper.

- This camper has no known allergies.
- This camper has an allergy to the following food(s): _____
- Does this cause anaphylaxis? Yes No
- Describe the reaction if this food is eaten and what can be done to manage it:

This camper is allergic to the following medication(s): _____

This camper is allergic to the following substance(s): _____

Does this cause anaphylaxis? Yes No

Describe the reaction and what can be done to manage it (attach any additional information if needed):

please describe) _____

Dietary Modifications: We can work effectively with medically prescribed diets if notified 2 weeks prior to camper's arrival; however we cannot cater to individual food preferences. Please call if you have a question about diet.

- This camper eats a regular and varied diet.
- This camper is a vegetarian.
- This camper is lactose intolerant (Check one):
 - This camper uses a Lactase Enzyme and/ or can appropriately manage this intolerance.
 - This camper needs a lactose-free diet, including baked items.

General Health History: This camper has had:

- Mononucleosis
- Mumps
- This camper has hearing within normal ranges
- This camper frequently gets up at night to use the bathroom.
- Chicken Pox
- Hay Fever
- This camper has vision within normal range.
- Measles
- German Measles
- This camper typically makes noise while sleeping

This camper is free from illness, injury, or surgery which would affect participation... Yes No
 Females: This camper has been told about menstruation and/or has a regular history... Yes No

Chronic Health Concerns: Check all that pertain to this camper and provide information that would aid in providing supportive health care and a supportive environment.

- This camper has no chronic concerns and is capable of full participation.
- This camper has the following chronic concern(s):
 - Asthma
 - Headaches
 - Diabetes
 - Menstrual Cramps
 - Heart Defect
 - Hypertension
 - Many Ear Infections
 - Seizure Disorder
 - Bleeding Disorder
 - Frequent Colds

Other (please describe) _____
 Additional Information about checked items(s): _____

Mental/ Emotional Health Concerns: Circle "Yes" or "No" for each statement.

This camper has an emotional health concern..... Yes No
 This camper has a learning disability..... Yes No
 This camper has been diagnosed with Attention Deficit Disorder (ADD or ADHD)..... Yes No
 This camper has been diagnosed with depression, panic or anxiety disorder, OCD..... Yes No
 This camper has been or is currently under professional care for emotional/ mental concerns..... Yes No

If "yes" was answered to anything in this section, please attach a statement if any special considerations should be taken.

Medication: Please complete all required information. All medications MUST be in the original pharmacy containers and labeled appropriately. Campers MUST turn in all medications, vitamins and over-the-counter drugs to the Health Care Person upon arrival. For the safety of your child and other campers self-medicating is not allowed

- This camper does not take any medication.
- This camper takes routine medication (please complete the following):

Name of Medication: _____	Name of Medication: _____
Reason: _____	Reason: _____
Dose: _____	Dose: _____
Times of Day: _____	Times of Day: _____

Immunization: Please note month and year of the shots or the most recent booster.

DTP: Diphtheria, Tetanus, Pertussis _____ TD: Tetanus Booster _____
 MMR: Measles, Mumps, Rubella _____ IVP/OPV: Polio _____
 Typhoid _____ Hep B: Hepatitis B _____
 Hib: Influenza, Type B _____ thers: _____

Doctor/ Dentist Contact Information:

Name of Camper's Physician _____ Phone _____
 Name of Camper's Dentist/ Orthodontist _____ Phone _____

IMPORTANT: This box must be signed for camp attendance

Parent/ Guardian Authorization for Health Care: This Health Form is complete and correct, and the person described has permission to engage in all camp activities except as noted by me and/or the examining physician. I give permission to the camp to: 1) provide ongoing health care, and 2) select medical personnel and to order X-rays or routine tests or treatment for the camper listed above. In the event that I cannot be reached in an EMERGENCY, I give permission to the physician selected by the Camp Director to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for my child named above. I understand that information about my child's health will be shared on a "need to know" basis with other Luther Crest staff. This form may be photocopied for use out of camp.

I give my permission for my child to attend Luther Crest Bible Camp Day Camp and to take part in the normal activities. Luther Crest assumes secondary insurance coverage; the camper's family assumes primary coverage. I also give Luther Crest permission to use any photograph of my child taken at camp in the future promotion of Luther Crest.

Signature of Parent/Guardian: _____ Date: _____