



Dates Coming \_\_\_\_\_

## CAMPER HEALTH, EMERGENCY AND AUTHORIZED INFORMATION FORM

It is **RECOMMENDED** but not required that this form (back side) be signed by a licensed medical person (i.e.: licensed physician, certified nurse practitioner, or other medical personnel licensed by the state to conduct health examinations.) It **IS REQUIRED** that this form (front and back) be completed and signed by the parent/legal guardian of a camper under 18 years of age.

Camper's Name \_\_\_\_\_  Male  Female  
Last First Mid Int

Birth Date \_\_\_\_\_

Home Address \_\_\_\_\_  
Street City State Zip

Custodial Parent/Guardian Name \_\_\_\_\_ Home Phone \_\_\_\_\_  
Cell or Work Phone \_\_\_\_\_

Second Parent/Guardian Name \_\_\_\_\_ Home Phone \_\_\_\_\_  
Cell or Work Phone \_\_\_\_\_

**IF ABOVE IS NOT AVAILABLE IN AN EMERGENCY, NOTIFY:**

Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Relationship \_\_\_\_\_ Cell or Work Phone \_\_\_\_\_

Name of Physician \_\_\_\_\_ Telephone \_\_\_\_\_

Name of Dentist/Orthodontist \_\_\_\_\_ Telephone \_\_\_\_\_

Name of Optometrist \_\_\_\_\_ Telephone \_\_\_\_\_

**THIS BOX MUST BE COMPLETED FOR ATTENDANCE**

I understand and certify that my child's participation in Luther Point Bible Camp (LPBC) and its activities is completely voluntary and I have familiarized myself with LPBC's program and activities. I recognize that certain hazards and dangers are inherent in LPBC events and programs and I acknowledge that although LPBC has taken safety measures to minimize the risk of injury, LPBC cannot insure nor guarantee that the participants', equipment, premises and/or activities will be free of hazards, accidents, and/or injuries. I further recognize and have instructed my child in the importance of knowing and abiding by LPBC's rules, regulations and procedures for the safety of participants. I waive any claim against LPBC and/or its personnel for any lost articles; for any injury to my minor child; and/or any injury to myself. LPBC assumes secondary insurance coverage. I assume primary coverage.

**This health history is correct so far as I know, and the person named on this form has permission to engage in all camp activities except as noted.**

**AUTHORIZATION FOR TREATMENT:** In case of emergency, I understand that every effort will be made to contact the parent(s) or guardian(s) of the camper. In the event I cannot be reached, I hereby give permission to the medical personnel selected by Luther Point Bible Camp staff to order x-rays, routine tests, treatment, and necessary transportation for my child. I give permission to the physician selected by Luther Point Bible Camp to secure and administer treatment, including hospitalization, for my child as named on this form.

**AUTHORIZATION FOR TRANSPORTATION:** I hereby give permission for my child to be transported for off-site outings.

**AUTHORIZATION FOR USING LIKENESS:** I hereby give permission for photographs/video including my child and/or myself to be used in the promotion of LPBC and/or the ELCA.

**COMPLIANCE WITH ELECTRONICS POLICY:** I understand that LPBC does not allow any electronic devices except cameras and I certify that I have ensured my child's compliance with this policy.

**Signature of Camper's Parent/Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**INSURANCE INFORMATION** Is the participant covered by family medical/hospital insurance?  Yes  No

If so, indicate Carrier or Plan Name \_\_\_\_\_ Group # \_\_\_\_\_

Carrier address \_\_\_\_\_

Name of Insured \_\_\_\_\_ Relationship to participant \_\_\_\_\_

Policyholder ID number \_\_\_\_\_

**HEALTH HISTORY** (to be completed by Parent or Legal Guardian of camper)

**General Questions** (Explain "Yes" answers below).

The participant has or has had:

- |  |  |  |  |
|--|--|--|--|
| 1. Recent injury, illness or infectious disease? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 17. Diagnosed with a heart murmur?               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Chronic or recurring illness/condition?       | <input type="checkbox"/> Yes <input type="checkbox"/> No | 18. Back problems?                               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Been hospitalized?                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | 19. Problems with joints (e.g. knees, ankles)?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. In-Patient Mental Health Treatment?           | <input type="checkbox"/> Yes <input type="checkbox"/> No | 20. Orthodontic appliance being brought to camp? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Out-Patient Mental Health Treatment?          | <input type="checkbox"/> Yes <input type="checkbox"/> No | 21. Skin problems (e.g. itching, rash, acne)?    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Surgery?                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | 22. Diabetes?                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Frequent headaches?                           | <input type="checkbox"/> Yes <input type="checkbox"/> No | 23. Asthma?                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Head injury?                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 24. Mononucleosis in the past 12 months?         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Knocked unconscious?                          | <input type="checkbox"/> Yes <input type="checkbox"/> No | 25. Problems with diarrhea/constipation?         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Glasses, contacts or protective eye wear?    | <input type="checkbox"/> Yes <input type="checkbox"/> No | 26. Problems with sleepwalking?                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Frequent ear infections?                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | 27. If female, any abnormal menstrual history?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. Passed out during or after exercise?         | <input type="checkbox"/> Yes <input type="checkbox"/> No | If she has not menstruated, has the process      |  |
| 13. Been dizzy during or after exercise?         | <input type="checkbox"/> Yes <input type="checkbox"/> No | been explained?                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 14. Seizures?                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | 28. History of bed-wetting?                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 15. Chest pain during or after exercise?         | <input type="checkbox"/> Yes <input type="checkbox"/> No | 29. An eating disorder?                          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 16. High blood pressure?                         | <input type="checkbox"/> Yes <input type="checkbox"/> No | 30. Head lice in the past two months:            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|  |  | If yes, was proper treatment given?              | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please explain any "Yes" answers, noting question number. Give dates of occurrence.

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**ALLERGIES:** 1. List all known allergies. 2. Describe reaction if in contact with the allergen. 3. Describe how the reaction is treated.

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The camper is under the care of a physician for the following conditions: \_\_\_\_\_

Medically prescribed meal plan or dietary restrictions \_\_\_\_\_

Are there any indications for restricting his/her physical activities in any way? \_\_\_ Yes \_\_\_ No Explain: \_\_\_\_\_

Check here if all immunizations are up to date

If all immunizations are not up to date, please give all dates of immunization for:

Vaccine:	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP		_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)		_____	_____	_____	_____	_____	_____
Tetanus		_____	_____	_____	_____	_____	_____
Polio		_____	_____	_____	_____	_____	_____
MMR		_____	_____				
or Measles		_____	_____		Hepatitis B	_____	
or Mumps		_____	_____		Varicella	_____	
or Rubella		_____	_____		(Chicken Pox)		

**ROUTINE MEDICATIONS:** List **ALL** medications (including nonprescription drugs) taken routinely. Bring only enough medication to last the entire time at camp. Medications **MUST BE** labeled with a pharmacy label including directions, name of medication, name of physician. **DO NOT** bring any over-the-counter medications unless accompanied by a signed physician order.

<b>Medication</b>	<b>Dose</b>	<b>Time to Give</b>	<b>Reason for taking</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

<b>Route</b>	<b>#</b>	<b>Int.</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Camp staff use only

**Signature of Licensed Medical Examiner** \_\_\_\_\_ **Date of exam** \_\_\_\_\_

(See top section on front side of form.)