



Lutheran Outdoor Ministries Indiana-Kentucky

# Summer Camp HEALTH Form

**(DO NOT USE IF REGISTERING ONLINE)**

Camper's Full Name \_\_\_\_\_  Male  Female

Age \_\_\_\_\_ Birthdate \_\_\_\_\_

FIRST PARENT/Guardian Name \_\_\_\_\_ Parent Email \_\_\_\_\_

Cell Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

SECOND PARENT/Guardian Name \_\_\_\_\_

Cell Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

EMERGENCY CONTACT 1: Name/Relationship/Phone \_\_\_\_\_

EMERGENCY CONTACT 2: Name/Relationship/Phone \_\_\_\_\_

I understand and certify that my child's participation in the summer camp program is completely voluntary. I understand that certain hazards and dangers are inherent in the camp program, and I acknowledge that although Lutheran Outdoor Ministries has taken measures to minimize the risk of injury/illness to camp participants, Lutheran Outdoor Ministries cannot guarantee that the activities will be free of accidents or injuries. **I have considered the status of all family members in my household with respect to preexisting medical conditions and are aware that viruses can be passed between campers and/or brought home after camp. I have instructed my child in proper handwashing and physical distancing practices. Furthermore, I have instructed my child in the importance of abiding by the camp's rules and procedures for the safety of camp participants.**

I understand that parents are contacted in the event their child receives professional medical attention. In the event that I cannot be reached in an EMERGENCY, I hereby give permission to the attending physician secured by Lutheran Outdoor Ministries to hospitalize, secure proper treatment for, to order injections, anesthesia, or surgery for my child, and to provide routine health care and dispense medications.

Signature of Parent \_\_\_\_\_ Date \_\_\_\_\_

**If you carry medical insurance, please indicate:**

Insurance Carrier \_\_\_\_\_ Policy # \_\_\_\_\_

Insurance Carrier Phone Number \_\_\_\_\_ Policy Holder's Name \_\_\_\_\_

- |                             |                |                   |                  |
|-----------------------------|----------------|-------------------|------------------|
| ___ Frequent Ear Infections | ___ Asthma     | ___ Diabetes      | ___ Heart Defect |
| ___ Convulsions             | ___ Epilepsy   | ___ Hyperactivity | ___ ADD          |
| ___ ADHD                    | ___ Bedwetting | ___ Sleepwalking  |                  |

Allergies:

- |                |             |                        |                |
|----------------|-------------|------------------------|----------------|
| ___ Penicillin | ___ Aspirin | ___ Serious Poison Ivy | ___ Bee Stings |
|----------------|-------------|------------------------|----------------|

Immunizations: All immunizations must be up to date. Indicated dates of basic immunization or most recent booster.

- |           |             |               |                        |
|-----------|-------------|---------------|------------------------|
| _____ DPT | _____ Polio | _____ Measles | _____ Current Tetanus* |
|-----------|-------------|---------------|------------------------|

\*If date cannot be supplied, please initial: "In case of an emergency, the attending physician may administer a tetanus booster. \_\_\_\_\_"



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**Operations, Serious or Chronic Illnesses:**

**Dietary Modifications While At Camp:**

This health history record is correct as far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted by me. I also attest that the person herein described has had a medical examination within the past 24 months. An actual physical for camp is NOT necessary as long as all information is complete, correct, and that the camper has had a physical in the past 24 months.

Date of Last Physical \_\_\_\_\_

**Physical Restrictions: While At Camp:**

**Description of any current physical or psychological condition requiring medication, treatment or special restrictions or considerations while at camp:**

This person may take, under the health officer's or designee's supervision, the following medications or generic equivalents (as directed on label) on an as needed basis to manage illness and injury:

- Tylenol
- Ibuprofen
- Benadryl (for swollen bee stings)
- Antibiotic Cream
- Aloe, Solarcane (for sunburn)
- Calamine lotion (for poison ivy)
- Generic cough/sore throat lozenges

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

Name & Phone # of Family Physician \_\_\_\_\_

### **CAMPER MEDICATIONS WHILE AT CAMP**

All medications (prescribed and over-the-counter ointments, pills, etc.) must be left with the health supervisor at the time of camper check-in at registration. In order to ensure that your camper receives medications as you instruct, we ask that you fill in the form below. Be sure to list instructions for all medications you leave.

| <b>Medications</b> | <b>Dose Amount</b> | <b>Time(s) to be given</b> |
|--------------------|--------------------|----------------------------|
| 1. _____           | _____              | _____                      |
| 2. _____           | _____              | _____                      |
| 3. _____           | _____              | _____                      |

**X** \_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date