



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?
If she has not menstruated, has the process
been explained? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. Passed out during or after exercise? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 28. History of bed-wetting? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 13. Been dizzy during or after exercise? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 29. An eating disorder? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 14. Seizures? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 30. Head lice in the past two months:
If yes, was proper treatment given? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 15. Chest pain during or after exercise? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 16. High blood pressure? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

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

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

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.

Medication	Dose	Time to Give	Reason for taking
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Route	#	Int.
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Camp staff use only

Signature of Licensed Medical Examiner _____ **Date** _____
of exam _____

(See top section on front side of form.)