

**DAY CAMP HEALTH HISTORY FORM SUMMER 2019**

This Day Camp is a partnership between Luther Springs Camp and Retreat Center and your local congregation. We want to provide your child with the best possible week at camp including spiritual, physical, and social growth. You can help by carefully filling out this form. Health forms must be turned into the Day Camp coordinator no later than the first morning of the Day Camp.

**Each camper must have a completed Health Form on file or WILL NOT be admitted to Day Camp.**

PLEASE PRINT

Full Name of Camper \_\_\_\_\_

Age \_\_\_\_\_ Birth date \_\_\_\_\_  Male  Female

Camper's Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name (s) of Parent (s) or Guardian \_\_\_\_\_

Email: \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

If I cannot be reached in an emergency call: \_\_\_\_\_

Relationship: \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Name of Child's Physician: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Health Insurance Information:

LUTHER SPRINGS and the local congregation have secondary accident insurance. The parent/legal guardian is responsible for all charges associated with an accident or illness.

Carrier Name:

\_\_\_\_\_

Carrier Address:

\_\_\_\_\_

Policy #: \_\_\_\_\_ Phone \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_

Policy Holder's Social Security # \_\_\_\_\_ Policy Holder's Date of Birth \_\_\_\_\_

Medical Release and Authorization for Treatment

This day camp is a partnership between Luther Springs Lutheran Outdoor Ministries (LUTHER SPRINGS) and the local congregation listed above. The undersigned, as parent/legal guardian of the camper, authorizes LUTHER SPRINGS and the local congregation, its delegated leaders, directors, and medical personnel they have selected to consent to any medical/hospital care deemed necessary. I consent to the release of this health history and examination form to the emergency room, hospital, or doctor's office providing care. Day Camp leaders will endeavor, but are not required, to communicate with me prior to treatment. The undersigned releases LUTHER SPRINGS and the local congregation, and its designated leaders and directors from any liability and claims arising from any consent given in good faith in connections with diagnosis or treatment. I also give Luther Springs and/or Lutheran Outdoor Ministries of Florida authorization to use pictures of my child in future advertising forms. The undersigned certifies that he/she has full authority to sign this Release and Authorization. This completed form may be photocopied for trips off site.

Printed Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_ 13

CAMPER HEALTH HISTORY CONTINUED

Describe any current physical, mental or psychological health conditions requiring medication, treatment, or

Special restrictions or considerations while at camp:

\_\_\_\_\_  
\_\_\_\_\_

Activities from which the camper should be exempted for health or other reasons:

\_\_\_\_\_

Allergies: Please list any allergies (food, medicine, insect stings, etc.):

\_\_\_\_\_

Asthma: Severe Moderate Mild Triggers? \_\_\_\_\_

Nutritional/dietary restrictions:

\_\_\_\_\_

Diabetic? No Yes

Camper Medications:

**A first-aid kit will be present at all times. It contains the following medications: Tylenol, Motrin, Cold Medication and Antacids/Antidiarrheal. May your child receive these medications if needed?**

Yes No Comments: \_\_\_\_\_

IF YOUR CHILD NEEDS TO BRING ANY MEDICATION TO BE TAKEN DURING DAY CAMP HOURS PLEASE FILL OUT THE INFORMATION BELOW. All medications (including aspirin, vitamins) must be checked in with the local coordinator upon arrival.

I give my permission for the Local Coordinator or designated church volunteer to keep and administer the following medications:

Name of Med. \_\_\_\_\_ Dosage \_\_\_\_\_ How often \_\_\_\_\_

Name of Med. \_\_\_\_\_ Dosage \_\_\_\_\_ How often \_\_\_\_\_

Any special information concerning this medication?

\_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_