



Program: _____ Dates: _____

LUTHER SPRINGS **RETREATS** CAMPER HEALTH FORM

PLEASE COMPLETE THE ENTIRE FORM AND TURN IN AT CHECK-IN.
Each camper must have a completed health form to be admitted to a Luther Springs program.

Name _____
Last First MI

Birth Date _____ Age _____ Male Female

Parent/Guardian Names(s) _____ Relationship _____

Home Address _____ City _____ State _____ Zip _____

Please list phone numbers in the order we should call them if we need to get in touch with you during the retreat:

First Phone _____ Second Phone _____

Third Phone _____ Parent Email _____ Child Email _____

IF PARENT/GUARDIAN IS NOT AVAILABLE IN AN EMERGENCY, PLEASE CONTACT:

Emergency Contact #1 _____ Relationship _____

Home Address _____ City _____ State _____ Zip _____

1st Phone _____ 2nd Phone _____ 3rd Phone _____

Emergency Contact #2 _____ Relationship _____

Home Address _____ City _____ State _____ Zip _____

1st phone _____ 2nd phone _____ 3rd phone _____

Physician name _____ Phone _____

Dentist name _____ Phone _____

Health Insurance Information

Luther Springs does not provide camper sickness insurance, but does have secondary accident insurance. The parent/legal guardian has primary responsibility for all charges associated with an accident or illness.

Carrier Name _____

Carrier Address _____

Policy # _____ Phone _____

Policy Holder's Name _____

Policy Holder's Date of Birth _____

If you have an Rx card Bin # _____ ID # _____ Group # _____

MEDICAL RELEASE AND AUTHORIZATION FOR TREATMENT

The undersigned, as parent/legal guardian of the camper, authorizes Luther Springs, its delegated leaders, directors, and the 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. Luther Springs will endeavor, but is not required, to communicate with me prior to treatment. The undersigned releases Luther Springs 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. The undersigned certifies that he/she has full authority to sign this Release and Authorization. This completed form may be photocopied for trips off camp.

Printed Name _____ Signature _____ Date _____

IF THE PARTICIPANT IS UNDER 18 YEARS OF AGE A PARENT/GUARDIAN MUST SIGN THE MEDICAL RELEASE/AUTHORIZATION! A SIGNED RELEASE IS A PREREQUISITE TO PARTICIPATE IN CAMP!!

HEALTH HISTORY : Has/does the participant:

Yes	No	Yes	No
Had any recent injury, illness or infectious disease.... <input type="checkbox"/>	<input type="checkbox"/>	Ever had high blood pressure..... <input type="checkbox"/>	<input type="checkbox"/>
Have a chronic or recurring illness/condition..... <input type="checkbox"/>	<input type="checkbox"/>	Ever had back problems..... <input type="checkbox"/>	<input type="checkbox"/>
Have frequent headaches..... <input type="checkbox"/>	<input type="checkbox"/>	Ever had problems with joints (eg., knees, ankles).... <input type="checkbox"/>	<input type="checkbox"/>
Ever had a head injury..... <input type="checkbox"/>	<input type="checkbox"/>	Have any skin problems..... <input type="checkbox"/>	<input type="checkbox"/>
Have frequent ear infections..... <input type="checkbox"/>	<input type="checkbox"/>	Had mononucleosis in the past 12 months..... <input type="checkbox"/>	<input type="checkbox"/>
Ever passed out during or after exercise..... <input type="checkbox"/>	<input type="checkbox"/>	Have problems with sleepwalking..... <input type="checkbox"/>	<input type="checkbox"/>
Ever had chest pain during or after exercise..... <input type="checkbox"/>	<input type="checkbox"/>	Have a history of bed-wetting..... <input type="checkbox"/>	<input type="checkbox"/>
Ever had seizures..... <input type="checkbox"/>	<input type="checkbox"/>	Ever had an eating disorder..... <input type="checkbox"/>	<input type="checkbox"/>
Ever had an operation..... <input type="checkbox"/>	<input type="checkbox"/>	Been diagnosed as ADD or ADHD..... <input type="checkbox"/>	<input type="checkbox"/>

Please explain any "yes" responses _____

Are there any special health concerns of which the nursing staff should be aware? _____

Allergies: Hay Fever Poison Ivy Insect Stings Food _____ Other _____

Asthma: Severe Moderate Mild Triggers? _____

Nutritional/dietary restrictions: _____

Diabetic? No Yes Vegetarian? No Yes

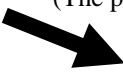
Has the camper had any of the following: Measles Chicken Pox Mumps German Measles

Please indicate the date of the last immunizations/booster for:
 DTP _____ MMR _____ TD (Tetanus) _____ Hepatitis B _____ HIB _____

Is camper currently taking any prescribed medicine? Yes No

If "yes", what medications? _____

(The person who brings the camper will sign a medication authorization form. Dosage instructions must match those prescribed.)

 **MEDICATIONS MUST BE IN CLOSED CONTAINERS WITH THE ORIGINAL PHARMACY LABELS INTACT.**
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Additional Information that can help us serve your child well:

Is this your child's first time at sleep-away camp? _____ at Luther Springs? _____

How does your child feel about attending this retreat? _____

What is your child most looking forward to about this retreat? _____


What concerns/fears does your child have about this retreat? _____

Is your child dealing with any situations or issues that might come up in cabin time or group discussion? If so, are there ways that the counselor can be supportive and helpful to your child? _____

Is there anything else that we should know? _____

PHOTOGRAPH PERMISSION

I hereby allow my child to be for possible inclusion in Luther Springs' publications or website.

 SIGNATURE OF CUSTODIAL PARENT/GUARDIAN*  _____
 DATE

THANKS FOR TRUSTING YOUR CHILD TO US FOR THIS FUN, FAITH-BUILDING RETREAT!