



LUTHER SPRINGS

264 Vause Lake Rd, Hawthorne, FL 32640

2010 CAMPER HEALTH FORM

PLEASE COMPLETE THE ENTIRE FORM AND RETURN TO LUTHER SPRINGS NO LATER THAN MAY 1ST

Health history must be filled out by parent or custodial guardians. **Update required annually.** Health exam (back page) must be completed

Name _____
Last First MI Name Used

Birth Date _____ Age _____ Male Female

Parent/Guardian Name(s) _____ Relationship _____

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____

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

Emergency Contact #1 _____ Relationship _____
 Home Phone _____ Work Phone _____ Cell Phone _____

Emergency Contact #2 _____ Relationship _____
 Home Phone _____ Work Phone _____ Cell Phone _____

Physician Name _____ Phone _____

HEALTH INSURANCE INFORMATION

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 # _____

- **THIS HEALTH HISTORY FORM IS CORRECT AND COMPLETE AS FAR AS I KNOW.**
- **THE PERSON HEREIN DESCRIBED HAS PERMISSION TO ENGAGE IN ALL CAMP ACTIVITIES EXCEPT AS NOTED.**

I hereby give permission to Luther Springs to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission for the camp to arrange necessary, related transportation, for me/my child.

In the event that I or the Emergency Contact cannot be reached in an emergency, I hereby give permission to the Health Care provider selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips off camp.

I hereby allow my child to be transported for off-site outings and photographed for possible inclusion in Luther Springs publications or the Luther Springs website.

Printed Name _____ Signature _____ Date _____

PAST MEDICAL TREATMENT & HEALTH HISTORY (to be filled out by parent/guardian)

Has/does the participant:

	Yes	No		Yes	No
Had recent injury, illness or diseases	<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"/>	Ever been diagnosed with ADD or ADHD	<input type="checkbox"/>	<input type="checkbox"/>

Please explain any "yes" responses _____

Describe any current physical, mental, or psychological conditions requiring medication, treatment, or special restrictions or considerations while at camp. _____

Describe any camp activities from which the camper should be exempted for health reasons. _____

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 attach immunization record or indicate the date (MM/YY) of the last immunization/booster for:

DTP _____ MMR _____ Hepatitis B _____ HIB _____

Does the camper know how to swim? Yes Somewhat No

MEDICATION

Please list **ALL** medications being taken by camper, including over-the-counter or nonprescription drugs. Bring enough medication to last the entire time at camp. **Keep ALL medications in their original packaging/bottle** with clear dosage and frequency instructions, name of medication, and prescribing physician if a prescription drug.

This person takes NO medications on a routine basis.

This person takes medications as follows:

Med #1 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med #2 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Attach additional pages for more medications if needed.

Also, please list meds taken during school year not taken during the summer.

Health Care Recommendations by Licensed Medical Personnel

PLEASE NOTE: Physician must either complete this section of the health form or a copy of a signed, completed physical from the last 24 months must be attached to this form.

I examined this individual on _____
 (date). Requirements specify exams occur within 24 months of camp attendance.

BP _____ Weight _____ Height _____

The applicant is under the care of a physician for the following condition(s). _____

In my opinion, the above applicant is is not able to participate in an active camp program.

Physician or other Medical Professional Certification (signature & printed name, credentials, and complete address below):

Signature: _____

Printed Name: _____

Address: _____

