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?	☐ Yes ☐ No	17.	Diagnosed with a heart murmur?	☐ Yes ☐ No
2.	Chronic or recurring illness/condition?	☐ Yes ☐ No	18.	Back problems?	☐ Yes ☐ No
3.	Been hospitalized?	☐ Yes ☐ No	19.	Problems with joints (e.g. knees, ankles)?	☐ Yes ☐ No
4.	In-Patient Mental Health Treatment?	☐ Yes ☐ No	20.	Orthodontic appliance being brought to camp?	☐ Yes ☐ No
5.	Out-Patient Mental Health Treatment?	☐ Yes ☐ No	21.	Skin problems (e.g. itching, rash, acne)?	☐ Yes ☐ No
6.	Surgery?	☐ Yes ☐ No	22.	Diabetes?	☐ Yes ☐ No
7.	Frequent headaches?	☐ Yes ☐ No	23.	Asthma?	☐ Yes ☐ No
8.	Head injury?	☐ Yes ☐ No	24.	Mononucleosis in the past 12 months?	☐ Yes ☐ No
9.	Knocked unconscious?	☐ Yes ☐ No	25.	Problems with diarrhea/constipation?	☐ Yes ☐ No
10.	Glasses, contacts or protective eye wear?	☐ Yes ☐ No	26.	Problems with sleepwalking?	☐ Yes ☐ No
11.	Frequent ear infections?	☐ Yes ☐ No	27.	If female, any abnormal menstrual history?	☐ Yes ☐ No
12.	Passed out during or after exercise?	☐ Yes ☐ No		If she has not menstruated, has the process been explained?	☐ Yes ☐ No
13.	Been dizzy during or after exercise?	☐ Yes ☐ No			
14.	Seizures?	☐ Yes ☐ No	28.	History of bed-wetting?	☐ Yes ☐ No
15.	Chest pain during or after exercise?	☐ Yes ☐ No	29.	An eating disorder?	☐ Yes ☐ No
16.	High blood pressure?	☐ Yes ☐ No	30.	Head lice in the past two months:	☐ Yes ☐ No
				If yes, was proper treatment given?	☐ Yes ☐ No

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

_____
_____
_____

ALLERGIES: *1. List <u>all known</u> 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 **<u>ALL</u>** medications (including nonprescription drugs) taken routinely. Bring only enough medication to last the entire time at camp. Medications **<u>MUST BE</u>** labeled with a pharmacy label including directions, name of medication, name of physician. **<u>DO NOT</u>** 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.)