Lutheran Outdoor Ministries Indiana-Kentucky

Summer Camp HEALTH Form

(DO NOT USE IF REGISTERING ONLINE)

Camper's Full Name ______________________________ ☐ Male ☐ Female

Age________Birthdate________________

FIRST PARENT/Guardian Name __________________________ Parent Email ____________________________

Cell Phone______________________________Business Phone ________________________________

SECOND PARENT/Guardian Name ______________________________________

Cell Phone______________________________Business Phone ________________________________

EMERGENCY CONTACT 1: Name/Relationship/Phone ____________________________________ EMERGENCY CONTACT 2: Name/Relationship/Phone ____

I understand and certify that my child's participation in the summer camp program is completely voluntary. I understand that certain hazards and dangers are inherent in the camp program, and I acknowledge that although Lutheran Outdoor Ministries has taken measures to minimize the risk of injury/illness to camp participants, Lutheran Outdoor Ministries cannot guarantee that the activities will be free of accidents or injuries**. I have considered the status of all family members in my household with respect to preexisting medical conditions and are aware that viruses can be passed between campers and/or brought home after camp. I have instructed my child in proper handwashing and physical distancing practices. Furthermore, I have instructed my child in the importance of abiding by the camp's rules and procedures for the safety of camp participants.**

I understand that parents are contacted in the event their child receives professional medical attention. In the event that I cannot be reached in an EMERGENCY, I hereby give permission to the attending physician secured by Lutheran Outdoor Ministries to hospitalize, secure proper treatment for, to order injections, anesthesia, or surgery for my child, and to provide routine health care and dispense medications.

Signature of Parent____Date ________________

If you carry medical insurance, please indicate:

Insurance Carrier____________________________________Policy # ______________________

Insurance Carrier Phone Number____________________Policy Holder's Name __________________________

____Frequent Ear Infections	____Asthma	____Diabetes	____Heart Defect
____Convulsions	____Epilepsy	____Hyperactivity	____ADD
____ADHD	____Bedwetting	____Sleepwalking	

Allergies:

____Penicillin	____Aspirin	____Serious Poison Ivy	____Bee Stings

Immunizations: All immunizations must be up to date. Indicated dates of basic immunization or most recent booster.

_______DPT _______Polio _______Measles ________Current Tetanus*

*If date cannot be supplied, please initial: "In case of an emergency, the attending physician may administer a tetanus booster._____

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Operations, Serious or Chronic Illnesses:

Dietary Modifications While At Camp:

This health history record is correct as far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted by me. I also attest that the person herein described has had a medical examination within the past 24 months. An actual physical for camp is NOT necessary as long as all information is complete, correct, and that the camper has had a physical in the past 24 months.

Date of Last Physical _____________

Physical Restrictions: While At Camp:

Description of any current physical or psychological condition requiring medication, treatment or special restrictions or considerations while at camp:

This person may take, under the health officer's or designee's supervision, the following medications or generic equivalents (as directed on label) on an as needed basis to manage illness and injury:

- ☐ Tylenol
- ☐ Ibuprofen
- ☐ Benadryl (for swollen bee stings)
- ☐ Antibiotic Cream
- ☐ Aloe, Solarcane (for sunburn)
- ☐ Calamine lotion (for poison ivy)
- ☐ Generic cough/sore throat lozenges

Parent's Signature______________________________Date __________

Name & Phone # of Family Physician ____

CAMPER MEDICATIONS WHILE AT CAMP

All medications (prescribed and over-the-counter ointments, pills, etc.) must be left with the health supervisor at the time of camper check-in at registration. In order to ensure that your camper receives medications as you instruct, we ask that you fill in the form below. Be sure to list instructions for all medications you leave.

Medications	Dose Amount	Time(s) to be given
1. ____________________	____________	______________________________
2. ____________________	____________	______________________________
3. ____________________	____________	______________________________

X_______________________________________ ____________

Parent/Guardian Signature Date