

Lutheran Outdoor Ministries Indiana-Kentucky Summer Camp HEALTH Form

Part Two --- Health Information

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 this statement: "In case of an emergency, the attending physician may administer a tetanus booster.")

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.

Date of Last Physical _____

Physical Restrictions: While At Camp:

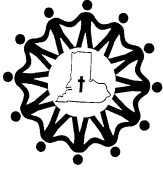
Description of any current physical or psychological condition requiring medication, treatment or special restrictions or considerations while at camp:

This person may take, under the health supervisor'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 _____



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Part Three --- Camper Medications

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
0. <u>Water</u>	<u>2 tablespoons</u>	<u>As needed</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

X _____
Parent/Guardian Signature

Date