

Shetek Lutheran Ministries Camper Health History Form 2012

PERSONAL INFORMATION *(to be completed by parent/guardian of minors or by adult campers/staff)*

Camper Name: _____ M/F: _____ Age: _____
Home Address: _____ Birthdate: _____
City: _____ State: _____ Zip: _____

EMERGENCY CONTACT INFORMATION

Parent(s)/Guardian Name(s) (Please include parent or guardian names)

Mother: _____ Phone: H (____) _____ W (____) _____ C (____) _____

Father: _____ Phone: H (____) _____ W (____) _____ C (____) _____

Emergency Contact (if parent/guardian cannot be reached)

Name: _____ Relationship to camper: _____

Phone: H (____) _____ W (____) _____ C (____) _____

Doctor: _____ Phone (____) _____ Dentist: _____ Phone (____) _____

INSURANCE

Do you carry family medical/hospital insurance? Y _____ N _____

Carrier Name: _____ Name of individual holding the policy: _____

Group Policy#: _____ Certificate Number: _____

MEDICATIONS

Medication Allergies: _____

Please do not pack over the counter medication. Camp has a stock of over the counter meds that can be administered by camp staff as needed. Any OTC meds not to be given to camper while at camp: _____

Please bring any prescription medications needed while at camp with you and fill out the following:

Medication Currently Taking:

Name	Dosage	Time to be Taken	Reason for Taking
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

IMMUNIZATION HISTORY

Is your child current on all immunizations needed for school? ___ Yes ___ No Date of last Tetanus: _____

List exceptions: _____

CAMPER HEALTH HISTORY *(use an additional piece of paper to respond if necessary)*

Does the camper have any food allergies or dietary concerns? ___ Yes ___ No

If yes, please describe the allergy/concern, as well as reaction and recommended intervention: _____

Does the camper have any nature allergies or any other allergies camp should be aware of? ___ Yes ___ No

If yes, please describe the allergy/concern, as well as reaction and recommended intervention: _____

(Camper Health History Continued) Describe injuries, operations, or illness requiring medical attention during the current or previous calendar years:

CAMPER CURRENT HEALTH

1. Describe any current conditions (injury, surgery, illness, other) that require special attention, restrictions or considerations while at camp:

2. Has the camper or is the camper currently receiving professional treatment to address mental/emotional health concerns? Yes No

If so, describe: _____

3. Has the camper been exposed to a communicable disease in the past 6 months? Yes No

If so, describe: _____

*****If you have entered information in #1 or given a "yes" in #2 or #3 of "Camper Current Health" you must have the following section completed by your attending health professional:**

PHYSICIAN'S RECOMMENDATIONS:

The camper named on this Health History is/has been under my care for the following: _____

Is the camper able to participate in an active camp program? Yes No (Detail "no" response listing details:) _____

Detail treatments to be continued while at camp: _____

If camper has been exposed to contagious disease, is period of contagion over? Yes No

Signature of Licensed Medical Personnel: _____ Date: _____

CONFIDENTIALITY STATEMENT

Information within this Health History document is considered confidential; the information will only be shared on a "need to know" basis.

Important! This portion must be signed for attendance

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted. Authorization for Treatment: I hereby give permission to the camp health care personnel to follow Shetek's health care plan, provide routine health care and to administer medications brought to camp; and to the medical personnel selected by the camp director to order X-rays, routine tests, treatment, and necessary transportation for me/or my child. I understand I will be contacted if my child needs medical treatment at a clinic or hospital. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment. These complete forms may be photocopied for trips out of camp.

Signature of parent/guardian or adult camper/staff: _____ Date: _____

This portion is to be filled out by CAMP STAFF

Camp Program: _____ Onsite: _____ Offsite: _____

Week at Camp: _____ Year: _____ Cabin #: _____ Counselor: _____

SCREENING:

1. Medications: None Required Received same as recorded Received with changes

2. Health History Review: Ok as is Changes

3. Observable Health: (Illness, Injury, Other) Good Concerns

Screened by: _____ Date: _____