

CAMP: On-Site Off Site
 Week at Camp: _____ Year: _____
 Cabin: _____ Counselor _____

Bring this form with you to camp!

Shetek Lutheran Ministries

Health History Form

(To be filled in by parents/guardian of minors or by adult campers/staff members themselves.)

Camper Name _____ M/F Birth Date _____ Age _____
 Address _____ City _____ State _____ Zip _____
 Parents/Guardian _____ Phone _____
 Alternate Contact _____ Phone _____

(Attach paper if more space is needed)

Health History			
<i>(Check and give approximate dates)</i>			
<input type="checkbox"/>	Frequent Ear Infections		
<input type="checkbox"/>	Sleep Walking		
<input type="checkbox"/>	Heart Defect/Disease		
<input type="checkbox"/>	Convulsions		
<input type="checkbox"/>	Fainting Spells		
<input type="checkbox"/>	Bleeding/Clotting Disorder		
<input type="checkbox"/>	Stomach Trouble		
<input type="checkbox"/>	Mononucleosis		
<input type="checkbox"/>	Frequent Sore Throat		
Diseases			
<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	Measles
<input type="checkbox"/>	Mumps	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	Kidney Problem	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	Other _____		
Immunizations (Include dates)			
<input type="checkbox"/>	DPT (Diphtheria Pertussis Tetanus)		
<input type="checkbox"/>	or TD (Tetanus Diphtheria)		
<input type="checkbox"/>	Polio	<input type="checkbox"/>	Other

Has this camper ever required any psychiatric counseling or hospitalization? Yes No Explain _____
 Operations or Serious Injuries (dates) _____
 Disability or chronic/recurring illness _____
 Environmental Allergies _____
 Activities encouraged or limited by physician _____

 Food Allergies _____
 Dietary Modifications _____
 Medication Allergies _____
 Medications Currently Taking _____

 Any over-the-counter Medication not to be given to camper while at camp _____
 Name of Dentist _____ Phone _____
 Name of physician _____ Phone _____
 Date of last physical Examination _____
Do you carry family medical/hospital insurance? Y N
 If so, indicate: Carrier _____
 Name of person holding the policy: _____
 Policy/Group # _____ Certificate # _____

Information on Form has been verified by
 Shetek's Health Care Manager: _____

Important – This Box 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 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. 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. The complete forms may be photocopied for trips out of camp.

Signature of parent/guardian or adult camper _____ Date _____

Physical Exam Form

(Filled out by Doctor only if Minor Camper has a Medical Condition)

Does the physical exam indicate that the applicant may participate in the usual physical and recreational facilities and programs of camping? Yes _____ No _____

Please indicate any restrictions: _____

Is the applicant free of communicable Disease? Yes _____ No _____

Signed _____ Date _____ Phone _____