

Name _____ Birthdate _____ Sex _____ Age _____
Parent or Guardian (or Spouse): _____
 Home Address _____ City _____ State _____ Zip _____ Phone _____
 Business Address _____ City _____ State _____ Zip _____ Phone _____
Emergency Contact: _____
 Home Address _____ City _____ State _____ Zip _____ Phone _____
 Family Physician: _____ Phone _____ Dentist: _____ Phone _____
 Medical Insurance: _____ Address: _____ Insured Name: _____

Medications Being Taken: List all meds. (including over-the-counter) taken routinely. Bring enough in original packaging with complete instructions for entire camp period.
Med. #1 _____ **Dosage** _____ **Times taken each day** _____ **Med. #2** _____ **Dosage** _____ **Times taken each day** _____
Allergies Please list all medication, food and other allergies. If you need additional room please attach.
 Allergy: _____ Reaction and management: _____
 Allergy: _____ Reaction and management: _____
Restrictions: Does not eat: Red Meat Pork Dairy Products Poultry Eggs Other _____
 Explain any activity restrictions or limitations: _____

Information about participant's behavior, physical, emotional, or mental health about which the camp should be aware: _____ (attach additional info. if needed)

Immunization History Please record the immunization date

Vaccine	date	date	date	date	date
DPT					
TD (tetanus/diphtheria)					
Polio					
MMR					
Or Measles					
Or Mumps					
Or Rubella					
Haemophilus influenza B					
Hepatitis B					
Varicella (chicken pox)					

- General Questions (explain "yes" below)** Yes No
- Recent injury or illness? Yes No
 - Chronic or recurring illness/condition? Yes No
 - Ever had seizures? Yes No
 - Ever had chest pain during or after exercise? Yes No
 - Have diabetes? Yes No
 - Have asthma? Yes No
 - If female, have an abnormal menstrual history? Yes No
 - Have a history of bed-wetting? Yes No
 - Ever had frequent ear infections? Yes No
 - Had mononucleosis in the past 12 months? Yes No
 - Ever had back problems? Yes No
 - Have frequent headaches? Yes No
 - Ever had high blood pressure? Yes No
- Please explain any "yes" answers: _____

Important - This box must be completed 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 medical personnel selected by the camp director to provide routine health care; to administer medications; order x-rays, routine tests, treatment, to release any records necessary for insurance purposes; and to provide or arrange necessary related 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, including hospitalization, for the person named above. The completed forms may be photocopied for trips out of camp.

★ **Signature** of parent or guardian or adult guest/staff _____ Date _____

Photo Release: I give permission and consent to allow photographs, videotapes, and interviews to be taken during the camp session. I further give consent that any such images or interviews may be published and used to illustrate and promote the camp and the National Lutheran Outdoors Ministry Association. ★ **Signed** (parent, guardian or adult camper/staffer) _____

For Camp Use - In-Camp Health Screening Record Date of screening _____ Time _____ Conducted by _____
 Meds Received at Screening _____
 Updates / Additions to health history noted [] Yes [] No [] None Required
 Current Health Needs Identified: _____
 Observational Notes _____