CAMPER HEALTH HISTORY FORM p.1

Mail this form to FLLC two (2) weeks prior to attendance

Dates will attend camp: from _____ to _____ Birth date:_____ Age when at camp: _____
Month/Day/Year Month/Day/Year

___ Male or ___ Female Camper Name: _____
First Middle Last

To Parent(s)/Guardian(s): *Please follow the instructions below. Attach additional information if needed.*

1) Complete all pages of this FORM and make a COPY.

2) Send the original, signed FORM to camp by the requested date. Keep a copy for yourself.

Camper Home Address:_____
Street Address City State Zip Code

Parent/Guardian with legal custody to be contacted in case of illness or injury: Email: _____

Name:_____ Relationship to camper:_____ Preferred Phone: ( )_____

Home Address: _____
(if different from above) Street Address City State Zip code

Other emergency contact information (Work, second parent/guardian, etc.):

Name:_____ Relationship to camper:_____ Preferred Phone: ( )_____

RELEASE NAMES: ***This child is allowed to be released to the following people (please list)***:

****This child is NOT ALLOWED release to the following people:_____***

(Attach additional information/explanation, if needed.)

Allergies: ___ No known allergies, or ___ This camper is allergic to: ___ Food, ___ Medicine, ___ The environment, ___ Other

(Please describe below what the camper is allergic to and the reaction seen. Attach additional information if needed.)

Diet, Nutrition: ___ This camper eats a regular diet. ___ This camper eats a regular *vegetarian* diet.

___ This camper has special food needs. ***(Please describe below. Attach additional information, if needed.)***

Note: dietary preferences can not be accommodated.

Restrictions: ___ I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.

___ I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations: ***(Please describe below. Attach additional information, if needed.)***

Medical Insurance:

This camper is covered by family medical/hospital insurance: ___ YES, or ___ NO

Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.

Insurance company:_____ Policy Number:_____

Subscriber:_____ Insurance Company Phone Number: ( )_____

CAMPER is aware of his/her own health needs: ___ YES, or ___ NO

Parent/Guardian Authorization for Health Care and FLLC Public Relations:

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the camp health officer for treatment and to refer further treatment to a physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status. I retain the responsibility for any and all bodily injury, loss or damage of property. I also hereby grant permission for Fortune Lake Lutheran Camp to use this camper's likeness in photos and quotes for future publicity.

Signature of Custodial Parent/Guardian:_____ Date:_____ Relationship to camper:_____

Signature of Camper:_____ Date:_____

Camper Name: First Middle Last (For Camp Use) Program, Cabin & Counselor:

CAMPER HEALTH HISTORY FORM p.2

Birth date:_____ Camper Name: _____
First Middle Last

Immunization History: Provide the month and year for each immunization. Starred (*) immunizations must be current. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

Diptheria, tetanus, pertussis*: _____ _____ _____ _____ Tetanus Booster*: _____ MCV4: _____

Polio (IPV)*: _____ _____ _____ _____ Mumps, Measles, Rubella*: _____ _____

Haemophilus influenza type B (HIB): _____ _____ _____ _____ Chicken Pox: _____ _____ *or had*: _____

Pneumococcal (PCV): _____ _____ _____ _____ Hepatitus A: _____ _____

Hepatitus B: _____ _____ _____ Has Hepatitus C*: ___YES or ___NO

Tuberculosis (TB) Test: _____ (___ negative, or ___ positive) OTHER:_____

If your camper has not been fully immunized, please sign the following statement:
I understand and accept the risks to my child from not being fully immunized.

Signature of Custodial Parent/Guardian:_____ Date:_____ Relationship to Camper:_____

Mental, Emotional, and Social Health: ***Check "Yes" or "No" for each statement.***

Has the camper :

1) Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? ___Yes, or ___No
2) Ever been treated for emotional or behavioral difficulties or an eating disorder?..... ___Yes, or ___No
3) During the past 12 months, seen a professional to address mental/emotional health concerns?..... ___Yes, or ___No
4) Had a significant life event that continues to affect the camper's life? ..... ___Yes, or ___No
   (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Please explain "Yes" answers in the space below or on page 3 if more space is needed, noting the section and question.
The camp may contact you for additional information.

Medication: ___ This camper will not take any daily medications while attending camp.

___ This camper **WILL TAKE** daily medications while at camp.
If Camper will be taking medications while at camp, you must complete Page 3 listing medications, times, dosages etc.

All prescriptions and over the counter medicines (*even vitamins & natural remedies*) **need to be listed**, and are required to be **in original pharmacy containers with labels**. Please provide enough of each medication to last the entire time the camper will be at camp.

General Health History: ***Check "Yes" or "No" for each statement. If "Yes", please attach an explanation and note the question.***

Has/does the camper:

Ever been hospitalized?..... ___Yes, or ___No
Have recurrent/chronic illnesses?..... ___Yes, or ___No
Had a recent injury?..... ___Yes, or ___No
Have diabetes?..... ___Yes, or ___No
Had headaches?..... ___Yes, or ___No
Ever had back/joint problems?..... ___Yes, or ___No
Have a history of bedwetting?..... ___Yes, or ___No
Have any skin problems?..... ___Yes, or ___No
Problems w/ diarrhea/constipation?... ___Yes, or ___No
Wear glasses, contacts or other?..... ___Yes, or ___No
Had appendicitis?..... ___Yes, or ___No
Has sinus infection/chronic sinusitis? ___Yes, or ___No
Has Hay Fever?..... ___Yes, or ___No
Has ulcers?..... ___Yes, or ___No
Any other medical concerns: please explain on page 3

Ever had surgery?..... ___Yes, or ___No
Had a recent infectious disease?..... ___Yes, or ___No
Had asthma/wheezing/shortness of breath?..... ___Yes, or ___No
Had seizures?..... ___Yes, or ___No
Had fainting or dizziness?..... ___Yes, or ___No
Passed out/had chest pain during exercise?..... ___Yes, or ___No
Had "mono" during the past 12 months?..... ___Yes, or ___No
If female, any problems w/ periods/menstruation? ___Yes, or ___No
Have problems w/ falling asleep or sleepwalking?.. ___Yes, or ___No
Traveled outside the country in past 9 months?..... ___Yes, or ___No
Has Hypertension/high blood pressure?..... ___Yes, or ___No
Has ear trouble?..... ___Yes, or ___No
Has tonsillitis?..... ___Yes, or ___No
Had/has whooping cough?..... ___Yes, or ___No

Name of camper's primary doctor(s):_____ Phone: ( )_____

Name of dentist(s)/orthodontist(s):_____ Phone: ( )_____

Signature of Custodial Parent/Guardian:_____ Date:_____ Relationship to Camper:_____

Have we forgotten anything? If so, please attach any other pertinent information. THANK YOU!

CAMPER HEALTH HISTORY FORM p.3

Birth date:_____ Camper Name: _____
First Middle Last

Please provide additional information if needed from any of the items on the previous pages, noting section and question for reference (attach additional sheet if needed):

The following non-prescription (over-the-counter) medications may be stocked in the Camp Health Office and are used on an as needed basis to manage illness and injury. **CROSS OUT THOSE ITEMS WHICH YOUR CAMPER SHOULD NOT BE GIVEN**:

*Acetaminophen (Tylenol) *Aloe *Antacid Tablets (Tums) *Antibiotic cream *Antihistamine/allergy medicine

*Busmuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol) *Calamine lotion *Dextromethorphan cough syrup (Robitussin DM)

*Diphenhydramine anthihistamine/allergy medicine (Benadryl oral or cream) *Generic cough drops *Guaifenesin cough syrup (Robitussin)

*Ibuprofen (Advil, Motrin) Insect repellent *Phenylephrine decongestant (Sudafed PE) *Pseudoephedrine decongestant (Sudafed)

*Sting Swabs *Sunburn Ointment *Sunscreen Other:

All prescriptions and over the counter medicines (*even vitamins & natural remedies*) **need to be listed below**, and are required to be **in original pharmacy containers with labels**. Provide enough of each medication to last entire time the camper will be at camp.

Name of medication	Date Started	Reason for taking it	When is it given	Amount or dose given	How is it given
			__Breakfast __Lunch __Dinner __Bedtime __Other:_____		
			__Breakfast __Lunch __Dinner __Bedtime __Other:_____		
			__Breakfast __Lunch __Dinner __Bedtime __Other:_____		

ENTRANCE SCREENING NOTES FOR CAMP USE ONLY:

Screening has been conducted according to camp protocol and significant findings noted as follows:

1. Any signs/symptoms of illness or injury upon arrival ___No ___Yes / describe:
2. History of exposure to communicable disease: ___No ___Yes / describe:
3. Additions or corrections to information on this health history form? ___No ___Yes / describe:

EXIT NOTES FOR CAMP USE ONLY:

____Camper left camp this day with no reported illness or injury symptoms.

____Camper left camp this day with the following problem/concern:_____

_____

_____

_____

____This person was told about the problem and instructed about follow-up as noted above:

_____ Date/Time_____

Have we forgotten anything? If so, please attach any other pertinent information. THANK YOU!