2025 CAMPER HEALTH HISTORY, p. 1 of 4, FLLC

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

YOUTH & VICTORY CAMPERS

To Parent(s)/Guardian(s): MUST BE SUBMITTED with Registration for ALL YOUTH CAMPER SESSIONS and VICTORY CAMPER SESSIONS. ***Please complete all pages of this FORM (attach additional sheets if needed); send the signed FORM to camp with Registration. Keep a copy for yourself, for ease of update if last minute changes need to be submitted. (for Victory Campers: submit this form AND the more detailed Victory Camp Level of Care Questionnaire to complete your registration process.)***

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 camper is allowed to be released to the following people (please list)***:

*****This camper 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 what the camper is allergic to and the reaction seen. Contact the Camp Director TWO weeks prior to your camper's start date if allergies are severe. Attach additional information if needed.)
Carries EpiPen ___yes* / ___no (***If yes**, provide details of anaphylaxis, including date and description of reaction, and PROVIDE two non-expired EpiPens: one for your child to carry with them and one for counselor/cabin.

Diet, Nutrition: ___ This camper eats a regular diet. ___ This camper eats a regular *vegetarian* diet.
___ This camper has special food needs*. ***(Please describe below, and contact the Camp Director TWO weeks prior to your camper's start date. 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.)***

Mental, Emotional, and Social Health: ***Check "Yes" or "No" for each statement.***
Has the camper :
Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? ___Yes, or ___No
Ever been treated for emotional or behavioral difficulties or an eating disorder?..... ___Yes, or ___No
During the past 12 months, seen a professional to address mental/emotional health concerns?..... ___Yes, or ___No
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.
If you check "YES" to any of these, contact the Camp Director TWO weeks prior to your camper's start date.

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 photos, videos, or other likeness for future publicity in print and digital form, including the use of social media such as, but not limited to, Facebook, Instagram, and Twitter. Fortune Lake will not include any identifying information about your camper.

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

Signature of Camper:_____ Date:_____

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

2025 CAMPER HEALTH FORM p.2

Birth date:_____ Camper Name: _____
First Middle Last

Immunization History: Provide the month/year for each immunization, or indicate if up to date. 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:_____
COVID-19 Vaccination: _____ _____ _____

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:_____

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:_____

Covered Subscriber:_____ Insurance Company Phone Number: ( )_____

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

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. (*Victory Campers see VC Level of Care Questionnaire)

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 just 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
Had COVID-19…….. ___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!

2025 CAMPER HEALTH 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)
*Antacid Tablets (Tums)
*Antihistamine/allergy medicine
*Calamine lotion
*Diphenhydramine anthihistamine/allergy medicine (Benadryl oral or cream)
*Guaifenesin cough syrup (Robitussin) *Ibuprofen (Advil, Motrin)
*Phenylephrine decongestant (Sudafed PE)
*Sting Swabs
List any Others:

*Aloe
*Antibiotic cream
*Busmuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)
*Dextromethorphan cough syrup (Robitussin DM)
*Generic cough drops
*Insect repellent
*Pseudoephedrine decongestant (Sudafed)
*Sunburn Ointment / *Sunscreen

All prescriptions and over the counter medicines (*even vitamins & natural remedies*) **need to be listed below** (add additional sheet if needed), and must be **in original pharmacy containers with labels;** provide just enough of each medication to last entire time the camper will be at camp. **VICTORY CAMPERS**: complete medications list on VC Level of Care Questionnaire instead of here.

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!