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.)***

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 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*: _____ _____ _____ _____ _____

Polio (IPV)*: _____ _____ _____ _____

Haemophilus influenza type B (HIB): _____ _____ _____ _____

Pneumococcal (PCV): _____ _____ _____ _____

Hepatitus B: _____ _____ _____

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

Tetanus Booster*: _____

Mumps, Measles, Rubella*: _____ _____

Chicken Pox: _____ _____ *or had*: _____

Hepatitus A: _____ _____

Has Hepatitus C*: ___YES, or ___NO

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 please attach a note, 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** the following daily medications while at camp. ***(Show medication & daily instructions)***
***Attach an additional note, if needed and note the specific section you are answering.*

* **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

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/sleepwalking?..... ___Yes, or ___No
Traveled outside the country in past 9 months?..... ___Yes, or ___No
Has Hypertension?.. ___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!