

Rainbow Trail Lutheran Camp 2015 Day Camp Health History Form

This form needs to be completely filled out by a parent/guardian. It will be kept by the Church staff.

Name _____ Birthdate: _____ Age _____ Male ___ Female ___
last first middle initial

Home Address _____

Parent/Guardian _____ Preferred Phone: (____) _____ Other Phone: (____) _____

Parent/Guardian _____ Preferred Phone: (____) _____ Other Phone: (____) _____

If unavailable in an emergency, please notify _____ Relationship _____ Phone: _____

Do you carry medical/hospital insurance? Yes ___ No ___ If so, please indicate:

Carrier _____ Group/policy number _____

Name of physician _____ Phone number _____

Date of last immunization for: Tetanus _____; DPT _____; Polio _____; Measles (MMR) _____

Please check and date any of the following, which have occurred to the camper or in the camper's family:

- | Conditions | Diseases | Allergies |
|--|---|--|
| <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Heart disease/defect | <input type="checkbox"/> Measles | <input type="checkbox"/> Ivy Poisoning, etc. |
| <input type="checkbox"/> Convulsions/seizures | <input type="checkbox"/> German Measles | <input type="checkbox"/> Insect Stings |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mumps | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Bleeding/clotting disorders | | <input type="checkbox"/> Other drugs |
| <input type="checkbox"/> Hypertension | | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Mononucleosis | | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Psychiatric counseling | | |

Please explain any of those checked in the space below:

Operations or serious injuries: (please list with dates)

Suggestions, any activity restrictions, or health-related information for camp personnel:

Will your child need to take a medication during Day Camp? _____
 Collected by Day Camp Coordinator

My child has permission to participate in all camp activities, except as noted. I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests and treatment for the health of 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 hospitalize or secure proper treatment (including surgery, injection, and/or anesthesia) for my child as named above.

Parent/Guardian signature _____ Date _____

Signature of witness _____ Date _____

Camper's signature _____