Health History Form

For Children, Youth and Adults at Lake Louise United Methodist Camp

The information in this form is to assist your camp staff in identifying appropriate care. Parent/guardian should fill out pages 1-3. Any changes to this form should be provided to the camp health officer upon check-in at camp. This form may be photocopied for your convenience.

Camper Name ______________________ Birthday ____________ Age at Camp ____
Last First Middle

Home Address ____
Street Address City State Zip

Home Phone ______________ Email ______________________ Gender Male Female
(Circle One)

Parent/Guardian Name ____

Home Address ____
(If Different) Street Address City State Zip

Phones (Home) ______________ (Bus) ______________ (Cell) ______________

Second Emergency Contact Name ____

Home Address ____
(If Different) Street Address City State Zip

Phones (Home) ______________ (Bus) ______________ (Cell) ______________

Parent/Guardian signatures *required* for attendance

Parent/Guardian Authorization: This health form is correct as far as I know and the camper has permission to engage in all camp activities except as noted.
Health Care: I give the camp health officer permission to give my child over-the-counter and prescription medications in accordance with the standing orders approved by the camp physician.
Emergency Authorization: I give permission to the medical personnel to order X-rays, routine tests and treatment for my child, and in the event I cannot be reached in an emergency. I give permission to the medical personnel to hospitalize, secure proper treatment and to order injection and anesthesia and/or surgery for my child. This form may be photocopied for use with medical personnel.
Transportation Authorization: I give permission for my child to be transported in a private vehicle, if necessary.

Signature of parent/guardian ______________________________ Date ______________

Printed Name ____

Camper Signature: I agree to abide by any restrictions placed on my participation in camp activities by my physician, or parents/guardian as described here ______________________________

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Signature of camper ______________________________ Date ______________

Health History

The following information must be filled in by the parent/guardian, or adult camper or staff/volunteer member.

Insurance Information: Is the camper covered by family medical/hospital insurance? Yes No

Carrier and Plan Name ________________________ Policy or group number ____________

Please attach a copy of your insurance card.

Describe dietary or activity restrictions: ____

____

Allergies	List all known	Reaction and management of reaction
Medication allergies (Penicillin, etc.)	____________	________________________
	____________	________________________
Insect bites & stings	____________	________________________
Food allergies	____________	________________________
Other allergies	____________	________________________

Medications Check here if this person takes **no** medications on a regular basis. ☐

List all medications taken on a regular basis or that camper will bring to camp. Prescription medication must be brought in original container. The dosage/frequency schedule identified by the physician will be administered by camp health officer. Bring enough medication to last the entire camp session. It is not recommended that extra medication be brought to camp. Leave gray area blank for camp health officer's notes.

Medication	Dosage	Specific time	Reason for taking
#1			
#2			
#3			
#4			
#5			
#6			
#7			

Notes:

Primary Physician Name ________________________ Phone ____________

Dentist Name ________________________ Phone ____________

Medical History Questions	Circle one	...Medical History Questions Continued	Circle one
Recent injury, illness, or infectious disease	Y N	Mononucleosis in the past 12 months	Y N
Chronic or recurring illness/condition	Y N	Ever had emotional difficulties for which professional help was sought	Y N
Autism **	Y N	Bleeding/clotting disorders	Y N
ADD or ADHD **	Y N	Wears glasses, contacts, or protective eye wear	Y N
Diabetes	Y N	History of sleep walking	Y N
Asthma	Y N	History of bed wetting	Y N
Has or had an eating disorder	Y N	Abnormal menstrual history	Y N
Seizures	Y N	Uses wheelchair or walker **	Y N
Heart Defect/Disease	Y N		

Please assist us so we can provide the best camping experience for your child!
If ** is indicated, please contact the camp director
3 weeks prior to the session to assist us with our staff and cabin assignments.

Provide an explanation for all questions to which you answered yes above.

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Immunization History

Date of most recent immunization.

Tetanus	________	Measles	________
Polio	________	Rubella	________
Mumps	________	Hepatitis B	________
Diphtheria	________	TB Test	________
Pertussis	________		

Result of last TB test (Circle One) Positive Negative

FOR CAMP PERSONNEL

Arrival Day Check-In

1. Emergency authorization on page one of this form signed? **Yes** **No**
2. Been exposed to any contagious disease in the last two weeks? **Yes** **No**

If yes, explain ____

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3. Brought over the counter or prescription medications? **Yes** **No**
   Additional medication form needed to list additional meds? **Yes** **No**
   (The Health Officer will need to record all medications brought to camp.)
4. Medical/social/physical condition of which camp staff should be informed? **Yes** **No**

If yes, explain ____

____

Staff member's initial ____________

Information Received from: Mother Father Grandparent Camper Other____________

Date, if different than registration date ____________