LUTHER CREST BIBLE CAMP
FAMILY HEALTH FORM AND PERMISSION TO PARTICIPATE

A complete health history IS necessary, and campers MUST have a signed and completed health form to attend camp A physical is required ONLY if there are any health problems, activity limitations, or if the camper is under doctor's care while attending camp. This form will be used by Luther Crest Bible Camp and medical professionals in the event of an emergency. Please take the time to fill it out thoroughly and completely.

PERSONAL INFORMATION

Family Address:____

Name	Date of Birth	Gender	Grade (2020-21)

EMERGENCY CONTACT

Please provide contact information for others who know your family and with whom we may consult if you are not available. We will assume you have spoken with these individuals and they are willing to assist if needed.

Name:______________________________ Relationship to Contact Adult:: ______________________

Phone Number 1: ______________________________ Phone Number 2: ______________________________

HEALTH CARE PROVIDERS

Primary: ______________________________ Phone: ______________________________

Camper's under this physician care:______________________________

Primary: ______________________________ Phone: ______________________________

Camper's under this physician care:______________________________

If additional Primary care providers, please list information: ______________________________

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Dentist/Orthodontist ______________________________ Phone: ______________________________

Camper's under this Dentist/Ortho's care:______________________________

Dentist/Orthodontist ______________________________ Phone: ______________________________

Camper's under this Dentist/Ortho's care:______________________________

If additional Dentist/Orthodontist, please list information: ______________________________

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INSURANCE INFORMATION

In the event of an accident/injury requiring medical attention, personal insurance will be considered the primary carrier. Camper medical and accident coverage must be provided by a parent or guardian. If medical care is necessary, please send bill to:

Insurance Company: ______________________________

Address: ______________________________

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Policy Number: ______________________________

Group/ID: ______________________________

Name of Policy Holder: ______________________________

If more than one Insurer, please list information here:______________________________

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DIET/NUTRITION

Please list each camper and check all that apply.

Camper Name	Regular	Vegetarian	Vegan	Lactose Intolerant	Other

If there is additional information you would like us to know about diet/nutrition, please list here_______________________________

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RESTRICTIONS

My Family is free from illness, injury, or surgery which would affect participation ☐ Yes ☐ No

If you checked "No", please explain:

____

____

GENERAL HEALTH HISTORY

Check any that apply

Mononucleosis		Diabetes		Mumps	
Chicken pox		Heart defect/disease		Headaches/Migraines	
Measles		Seizure disorder		German measles	
Hypertension		Abnormal hearing		Abnormal vision	
Asthma		Sleepwalking		Bleeding/Clotting Disorder	

Explain each checked item: ____

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MENTAL, EMOTIONAL AND SOCIAL HEALTH

Please check all that apply

Emotional health concerns	
Learning disability	
Diagnosed with Attention Deficit Disorder (ADD or ADHD)	
Diagnosed with depression, panic or anxiety disorder, OCD	
Under professional care for emotional/mental concerns	

Explain each checked item:

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IMMUNIZATIONS

My family participating in Family Camp is up to date on immunizations. ☐ Yes ☐ No
If you checked "No", please list camper(s) NOT fully immunized

____

____

If a camper is **NOT** fully immunized, please sign the following statement. I understand and accept the risks to myself and/or my family members from NOT being full immunized.

____

Signature Date

MEDICATIONS
Please list all medications used, including over-the-counter medications. If no medications are taken, type "None".

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____

ALLERGIES
List all allergies and reactions. If none, please write "none".

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WHAT HAVE WE FORGOTTEN TO ASK?
Please provide in the space below any additional information about the individual's health that you think important or that may affect the individual's ability to fully participate in the camp program.

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Parent/Guardian Authorization for Health Care *(Adults participating in a program will sign on their own behalf.)*
The privacy of you, of your family and of your child is very important to us. This Health Form and the information contained herein are only shared with a camper's Counselor, the Health Care Manager, the Camp Directors, and Hospital/Clinic Staff if required. This form will be securely stored in Luther Crest's records for 20 years - at which time it will be destroyed.

My child and/or my family have permission to participate in all aspects of the program of Luther Crest Bible Camp and I agree that the camp or its personnel will not be held responsible for accidents arising from participation. I also give permission for any pictures or video taken of me, our family and of my child to be used for promotional purposes.

This Health Form is complete and correct, and the person or persons described have permission to engage in all camp activities except as noted by me and/or the examining physician. I give permission to the camp to: 1) provide ongoing health care, and 2) select medical personnel and to order X-rays or routine tests or treatment for the camper listed above. In the event that I cannot be reached in an EMERGENCY, I give permission to the physician selected by the Camp Director to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for my child named above. I understand that information about my child's health will be shared with the appropriate counseling, food service, or other Luther Crest staff. This form may be photocopied for use out of camp.

To agree with the above statements, Family Campers 18 year or older, please sign below.

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Printed Name Signature Date

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Printed Name Signature Date

____

Printed Name Signature Date