

# 2021 LUTHER CREST BIBLE CAMP

## HEALTH FORM AND PERMISSION TO PARTICIPATE

Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  
 Session: \_\_\_\_\_



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. If the camper is required to have a physical for camp attendance, and has had one within the last 12 months, then a photocopy of the signed physical may be attached to this form.

Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  Male  Female  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ Grade (2020-21) \_\_\_\_\_  
 State/Province: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_

We will call you in case of an emergency requiring professional medical treatment or if we have questions about your child. Please provide contact information for others who know your child 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.

### PARENT/GUARDIAN #1

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 Phone #1: \_\_\_\_\_  
 Phone #2: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_  
 State/Province: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_

### PARENT/GUARDIAN #2

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 Phone #1: \_\_\_\_\_  
 Phone #2: \_\_\_\_\_

### EMERGENCY CONTACT

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Phone #1: \_\_\_\_\_  
 Phone #2: \_\_\_\_\_

### Health Care Providers

Primary: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Orthodontist: Phone: \_\_\_\_\_

### 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:

Parents/Guardians  Health insurance company listed below

Insurance Company: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Policy Number: \_\_\_\_\_ Group/ID: \_\_\_\_\_  
 Name of Policy Holder: \_\_\_\_\_

### Diet / Nutrition

Regular  Vegetarian  Vegan  Lactose Intolerant  Other:

\_\_\_\_\_  
 \_\_\_\_\_

### Restrictions

This camper is free from illness, injury, or surgery which would affect participation  Yes  No

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### General Health History

Check "Yes" or "No" for each statement. Explain "Yes" answers below.

- |  |  |  |
|--|--|--|
| 1. Mononucleosis?..... <input type="checkbox"/> Yes <input type="checkbox"/> No    | 9. Diabetes?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                   | 17. Frequent ear infections?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                 |
| 2. Chicken pox?..... <input type="checkbox"/> Yes <input type="checkbox"/> No      | 10. Heart defect/disease?..... <input type="checkbox"/> Yes <input type="checkbox"/> No      | 19. Frequent colds?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                          |
| 3. Measles?..... <input type="checkbox"/> Yes <input type="checkbox"/> No          | 11. Seizure disorder?..... <input type="checkbox"/> Yes <input type="checkbox"/> No          | 20. Frequent nighttime bathroom use?..... <input type="checkbox"/> Yes <input type="checkbox"/> No         |
| 4. Mumps?..... <input type="checkbox"/> Yes <input type="checkbox"/> No            | 14. Headaches?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                 | 21. Makes noise when sleeping?..... <input type="checkbox"/> Yes <input type="checkbox"/> No               |
| 5. German measles?..... <input type="checkbox"/> Yes <input type="checkbox"/> No   | 13. Sleepwalking?..... <input type="checkbox"/> Yes <input type="checkbox"/> No              | 22. For females, been told about menstruation?... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Abnormal hearing?..... <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. Hypertension?..... <input type="checkbox"/> Yes <input type="checkbox"/> No              | 23. For females, has menstrual cramps?..... <input type="checkbox"/> Yes <input type="checkbox"/> No       |
| 7. Abnormal vision?..... <input type="checkbox"/> Yes <input type="checkbox"/> No  | 15. Bleeding/clotting disorder?.... <input type="checkbox"/> Yes <input type="checkbox"/> No | 24. For females, has a regular periods?..... <input type="checkbox"/> Yes <input type="checkbox"/> No      |
| 8. Asthma?..... <input type="checkbox"/> Yes <input type="checkbox"/> No           | 16. Bedwetting?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                |  |

### Mental, Emotional, And Social Health

Check "Yes" or "No" for each statement. Explain "Yes" answers below.

- |  |   |
|--|---|
| 1. Emotional health concerns?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                              | 4. Diagnosed with depression, panic or anxiety disorder, OCD?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Learning disability?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                                    | 5. Under professional care for emotional/mental concerns?..... <input type="checkbox"/> Yes <input type="checkbox"/> No     |
| 3. Diagnosed with Attention Deficit Disorder (ADD or ADHD)?.... <input type="checkbox"/> Yes <input type="checkbox"/> No |   |

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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### Immunization History

Provide the month and year for each immunization.

	Dose 1 (Month/Year)	Dose 2 (Month/Year)	Dose 3 (Month/Year)	Dose 4 (Month/Year)	Dose 5 (Month/Year)
Diphtheria, tetanus, pertussis (DTaP or TdaP)	_____	_____	_____	_____	_____
Mumps, measles, rubella (MMR)	_____	_____	_____	_____	_____
Polio (IPV)	_____	_____	_____	_____	_____
Haemophilus influenzae type B (HIB)	_____	_____	_____	_____	_____
Pneumococcal (PCV)	_____	_____	_____	_____	_____
Hepatitis B	_____	_____	_____	_____	_____
Hepatitis A	_____	_____	_____	_____	_____
Varicella (Chicken Pox)	_____	_____	<input type="checkbox"/> Had Chicken Pox?	Date: _____	
Meningococcal meningitis (MCV4)	_____	_____	_____	_____	_____

**TB Test** Date: \_\_\_\_\_  
 Negative  Positive

**Tetanus** (dT or TdaP) Date: \_\_\_\_\_

**Influenza**  
 Seasonal Date: \_\_\_\_\_  
 H1N1 Date: \_\_\_\_\_

If camper is **NOT** fully immunized, please sign the following statement: I understand and accept the risks to my child from **NOT** being fully immunized.

Printed Name \_\_\_\_\_ Relationship to Camper \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

### Medications

No Medications

All medications MUST be in the original pharmacy containers and labeled appropriately. Campers MUST turn in all medications, vitamins and over-the-counter drugs to the Health Care Person upon arrival. For the safety of your child and other campers self-medicating is not allowed.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Allergies List all allergies and reactions

No Known Allergies  Drug  Food  Environmental

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### 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.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### 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.

Name \_\_\_\_\_ Relationship to Camper \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_