

LUTHER CREST BIBLE CAMP

FAMILY HEALTH FORM & PERMISSION TO PARTICIPATE

Name: _____
 Date of Birth: _____
 Session: _____



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: _____
 Policy Number: _____
 Name of Policy Holder: _____

DIET/NUTRITION

Please list each camper and check all that apply.

Camper Name	Regular	Vegetarian	Vegan	Lactose Intolerant	Other

RESTRICTIONS

This camper is free from illness, injury, or surgery which would affect participation

Name	Yes	No

GENERAL HEALTH HISTORY

Check any that apply

Mononucleosis	Diabetes	Frequent ear infections
Chicken pox	Heart defect/disease	Frequent colds
Measles	Seizure disorder	Frequent nighttime bathroom use
Mumps	Headaches	Makes noise when sleeping
German measles	Sleepwalking	For females, been told about menstration
Abnormal hearing	Hypertension	For females, has menstrual cramps
Abnormal vision	Bleeding/clotting disorder	For females, has a regular period
Asthma	Bedwetting	

Explain each checked item:

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MENTAL, EMOTIONAL AND SOCIAL HEALTH
 Please check all that apply

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

Explain each checked item:

IMMUNIZATIONS

Name	Camper has been fully immunized with all up to date immunizations	Camper has not been fully immunized

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(s): _____

Signature: _____

Date: _____

TB TEST

Name	Date of TB Test	Positive	Negative

TETNIS/INFLUENZA

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Name	Date of Tetnis	Date of Influenza

ALLERGIES & MEDICATIONS

Check all that apply

Name	Has food allergies	Has medication allergies	Has environmental allergies (insect stings, hay fever, etc.)	Takes medications on a routine basis

Explain each checked item:

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

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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.

Printed Name: _____ Date: _____

Signature: _____

Printed Name: _____ Date: _____

Signature: _____

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