LGP District Camp Permission Form

One form per camper ***(including adults)***

Please send a photo of your Girl Pioneer for the nurse to keep with this form.

Participants Name_____ Birthdate_____ Sex_____ Age_____

Parent or Guardian (or Spouse)

_____

Home Address_____ City_____ State_____ Zip_____ Phone_____

Emergency Contact_____Home #_____Cell #_____

Family Physician_____ Phone_____ Dentist_____ Phone_____

Medical Insurance_____Subscriber Name & DOB_____

Policy#_____ Address_____

Medication Being Taken: List all meds, including over-the-counter. Bring enough **for entire camp period** in **the** original packaging with complete instruction.

Med #1_____ Dosage_____ Times taken each day_____ Med #2_____ Dosage_____ Times taken each day_____

Med #3_____ Dosage_____ Times taken each day_____ Med #4_____ Dosage_____ Times taken each day_____

Allergies: Please list all medication, food & other allergies. If you need additional room please use back.

Allergy_____ Reaction & management_____

General Questions (explain "yes" on back)	**YES**	**NO**
1. Recent injury or illness?	☐	☐
2. Chronic or recurring illness/condition?	☐	☐
3. Ever had seizures?	☐	☐
4. Ever had chest pain during or after exercise?	☐	☐
5. Have diabetes?	☐	☐
6. Have asthma?	☐	☐
7. If female, have an abnormal menstrual history?	☐	☐
8. Have a history of bed-wetting?	☐	☐
9. Ever had frequent ear infections?	☐	☐
10. Had mononucleosis in the past 12 months?	☐	☐
11. Ever had back problems?	☐	☐
12. Have frequent and/or severe headaches?	☐	☐
13. Ever had high blood pressure?	☐	☐
14. Have bleeding/clotting disorder?	☐	☐
15. Nosebleeds?	☐	☐
16. Ever fainted?	☐	☐
17. Have sleep walking?	☐	☐
18. Car sickness?	☐	☐
19. Stomach aches?	☐	☐

Dietary Restrictions_____

Explain any activity restrictions or limitations_____

_____

Information about participant's behavior, physical, emotional, or mental health which the camp staff should be aware of _____

_____

Date of last Tetanus shot (**Must have date to be admitted to camp**)

_____

Any over-the-counter medication **NOT** to be given to camper while at camp

_____

Important – This box must be complete for attendance

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted. Authorization for Treatment: I hereby give permission to the medical personnel selected by the camp director to provide routine health care; to administer medication; order x-rays, routine tests, treatment, to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or 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 secure and administer treatment, including hospitalization, for the person named above. I accept the responsibility for all costs thus incurred, and waive any claim against the District or National Organization, The Lutheran Girl Pioneers, Inc., or any individual at camp for any and all cases which may arise in connection with the above. Permission is here by granted to transport my child for activities. The complete form may be photocopied for trips out of camp.

Adults- NO ALCOHOL is allowed at camp. By signing below you agree to abide by these conditions.

Signature of parent/guardian or adult guest/staff_____ Date_____

Camp Personnel Use Only

IN-CAMP HEALTH SCREENING RECORD: Date of screening_____ Time_____ Conducted by _____

Med Received at Screening_____

Updates/Additions to health history noted ☐ Yes ☐ No ☐ None required

Current Health Needs Identified and other Observational Notes_____

Payment received_____