NAME:	PROGRAM:	DATES:	SITE:

HEALTH AND EXAMINATION FORM FOR YOUTH & ADULTS

LUTHERAN RETREATS, CAMPS & CONFERENCES

Please be thorough in completing this Health Form. Use one form per person. ***ALL PARTICIPATING CAMPERS MUST HAVE A PHYSICIAN'S EXAMINATION WITHIN TWO YEARS PRIOR TO COMING TO AN LRCC PROGRAM.***

For El Camino Pines: 11900 Frontier Rd., Frazier Park, CA 93225
For Beach Camp or Luther Glen: 39136 Harris Rd., Oak Glen, CA 92399

Camper or Adult:

Name *last*_____*first*_____Birthdate_____

Gender ___ Age ___ Camp Program(s) _____ Program Dates _____

Parent/Guardian _____ or Spouse _____

Home Phone (____)_____ Work Phone (____)_____

Cell Phone (____)_____ Email _____

Home Address _____

City _____ State _____ Zip _____

Emergency Contact *(other than parent or spouse)*:

Name *last*_____*first*_____

Day Phone (___)_____ Night Phone (___)_____

Insurance Is the participant covered by family medical insurance? ☐ Yes ☐ No

Insurance Carrier or Plan Name _____

Group # _____

(***Photocopy of front and back of health insurance card must be attached to this form.***)

Health History (Explain "yes" answers below.)

Has/does the participant:	Yes	No		Yes	No
1. Had any recent injury, illness or infectious disease?	☐	☐	11. Have an orthodontic appliance being brought to camp?	☐	☐
2. Have a chronic or recurring illness/ condition?	☐	☐	12. Have diabetes?	☐	☐
3. Ever been hospitalized?	☐	☐	13. Have asthma?	☐	☐
4. Ever had surgery?	☐	☐	14. Had mononucleosis in the past 12 months?	☐	☐
5. Have frequent headaches?	☐	☐	15. Had problems with diarrhea/ constipation?	☐	☐
6. Ever had a head injury?	☐	☐			
7. Ever been knocked unconscious?	☐	☐	16. Sleepwalk?	☐	☐
8. Ever had frequent ear infections?	☐	☐	17. Have a history of bedwetting?	☐	☐
9. Ever had seizures?	☐	☐	18. Ever had an eating disorder?	☐	☐
10. Ever had high blood pressure?	☐	☐	19. Have emotional difficulties?	☐	☐

Please explain any "yes" answers, noting the number of the questions.

_____

_____

_____

_____

_____

Medication Allergies (list) **Describe reaction and management of reaction.**

_____ _____

_____ _____

_____ _____

Food Allergies (list) **Describe reaction and management of reaction.**

_____ _____

_____ _____

_____ _____

Other Allergies (list) **Describe reaction and management of reaction.**

_____ _____

_____ _____

_____ _____

Medications Will the camper/adult be bringing any medications to camp? ☐No ☐Yes

This person takes medications as follows: (include prescription and over-the-counter meds)

Med #1 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med #2 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med #3 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Please attach additional pages for more medications. Both ***over-the-counter and prescription medications*** *to be administered at camp must be in the* ***original pharmacy-labeled containers*** *with the patient's name, dosage, times of administration, and any special instructions clearly stated. Please, only one medication per container.*

For Females Has she menstruated? ☐Yes ☐No

If yes, is her menstrual history normal? _____ If no, does she know about it? _____

Other Special Considerations _____

_____

Authorization and Permission to Provide Necessary Treatment or Emergency Care:

The above information is complete and accurate to the best of my knowledge. I hereby give permission to the medical personnel selected by the Executive Director or his/her appointee to provide routine health care; to administer medications; to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide 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 Executive Director or his/her appointee to secure and administer treatment, including hospitalization, for the person named above. This form may be photocopied for trips out of camp.

Signature of Parent/ Guardian or Adult _____ *Date*_____

Please also complete the backside!!!

Health Care Recommendations by Licensed Medical Personnel

I examined this individual on _____.

(ACA-accreditation requirements specify exams within 24 months of camp attendance.)

Ht. _____ Wt. _____ BP _____

In my opinion, this individual ☐ *is* ☐ *is not* able to participate in an active camp program.

This individual is under the care of a physician for the following conditions:

_____

_____

_____

_____

_____

Recommendations and Restrictions at Camp:

_____

_____

_____

_____

_____

Signature of Licensed Medical Personnel _____

Printed _____ Title _____

Address _____

Phone _____ Date _____

Immunization History: ***Please Note:*** Immunization dates must be on file with LRCC. Stating that immunizations are current or up to date is not adequate. This information is available from your physician, pediatrician or school nurse.

Vaccine: Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP	_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)	_____	_____	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____	
MMR	_____	_____				
or Measles	_____	_____				
or Mumps	_____	_____				
or Rubella	_____	_____				
Haemophilus influenza B	_____	_____	_____	_____		
Hepatitis B	_____	_____	_____			
Varicella (chicken pox)DTP	_____	_____				

Non-Prescription Medication Permission.

I hereby grant LRCC and its employees permission to dispense the following over-the-counter medications.

Signature _____ Date _____

(Please check all medications LRCC has permission to dispense to the individual and list any special instructions.)

	Medication	Special Instructions
☐	Tylenol	_____
☐	Ibuprofen	_____
☐	Decongestants	_____
☐	Antihistamines	_____
☐	Tums/Rolaids	_____
☐	Pepto Bismol	_____
☐	Hydrocortisone Cream	_____
☐	Caladryl	_____
☐	Midol	_____
☐	Other	_____
☐	Other	_____
☐	Other	_____

Please list any dietary concerns:

_____

_____

_____

_____

_____

Parent/Guardian Notification Policy

On rare occasions, due to health or safety concerns, campers are unable to complete the full camp program. If any of the following situations occur, a parent/guardian will be contacted and the appropriate measures will be decided upon.

- ☐ A camper with a fever over 100 degrees.
- ☐ A camper who is excessively sick and/or is in the health care center for over 12 hours.
- ☐ A camper who makes three or more visits to the health care center because of an illness.
- ☐ A camper who is taken to emergency care.
- ☐ A camper who is a danger to his/herself and/or others.