LUTHER CREST BIBLE CAMP
HEALTH FORM AND PERMISSION TO PARTICIPATE
Day Camp 2023

Please complete the following health form. Campers **MUST** have a **signed** and **completed** health form to attend camp.

Camper Name: ____
Last First Middle Initial

Mailing Address: ____

City, State, ZIP: ____

Gender: ____________ Age: __________ Birth Date: ______________ Grade Completed ('22 –'23 School Year): _______

Parent/Guardian: ______________________________ Day Phone Number: ____________________

Relationship: ______________ Evening Phone Number: _________________ Cell Phone Number: __________________

Insurance/Billing Information: In the event of an accident or injury requiring medical attention, your personal insurance will be considered **PRIMARY CARRIER**.

Company Name: ____

Policy Number: ____

In the event the above named camper needs to see a Doctor while at camp, the bill should be sent directly to:
*(Please **Check one**)* ☐ To the Parents ☐ To the Parents' Health Insurance Company

Health History: Luther Crest uses this information to…
1) Provide health care with an informed background about your child;
2) Educate counseling staff about their respective camper needs;
3) Brief kitchen staff about dietary needs (onsite only).

Allergies/Food Restrictions: Check those which apply to this camper.

- ☐ This camper has no known allergies.
- ☐ This camper has an allergy to the following food(s), medication(s), and/or substance(s): ______________________

Do any of these allergies this cause anaphylaxis? ☐ Yes ☐ No
Describe the reaction(s) and what can be done for management (attach any additional information if needed):
____
____

General Health History: This camper has had:

☐ Mononucleosis ☐ Chicken Pox ☐ Measles
☐ Mumps ☐ Hay Fever ☐ German Measles
☐ This camper has hearing within normal ranges. ☐ This camper has vision within normal range.
This camper is free from illness, injury, or surgery which would affect participation…..☐ Yes ☐ No

Chronic Health Concerns: Check all that pertain to this camper and provide information that would aid in providing supportive health care and a supportive environment.

- ☐ This camper has no chronic concerns and is capable of full participation.
- ☐ This camper has the following chronic concern(s):

☐ Asthma ☐ Diabetes ☐ Heart Defect/Disease ☐ Seizure Disorder
☐ Hypertension ☐ Frequent Colds ☐ Frequent Ear Infections ☐ Bleeding/Clotting Disorder
☐ Other (please describe) ____
Additional Information about checked item(s): ______________________________

Mental/Emotional Health Concerns: Check "Yes" or "No" for each statement.

This camper has an emotional health concern... □ Yes □ No

This camper has a learning disability.. □ Yes □ No

This camper has been diagnosed with Attention Deficit Disorder (ADD or ADHD)..................... □ Yes □ No

If "yes" was answered to anything in this section, please attach a statement if any special considerations should be taken

Medication: Please complete all required information. 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.

□ This camper does not take any medication.

Name of Medication: ______________________

Reason: ______________________

Dose: ______________________

Time(s) of Day: ______________________

□ This camper takes routine medication (complete the following):

Name of Medication: ______________________

Reason: ______________________

Dose: ______________________

Time(s) of Day: ______________________

Immunization: Please note month and year of the shots or the most recent booster.

DTP: Diphtheria, Tetanus, Pertussis ____________

MMR: Measles, Mumps, Rubella ____________

Td: Tetanus Booster ______________________

Others: ______________________

Doctor/Dentist Contact Information:

Name of Camper's Physician ______________________ Phone ______________

THIS FORM MUST BE SIGNED FOR CAMP ATTENDANCE.

Parent/Guardian Authorization for Health Care: This Health Form is complete and correct, and the person described has 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.

Parent/Guardian Permission to Participate: My child has permission to participate in all aspects of the Day Camp 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 my child to be used for promotional purposes.

Signature of Parent/Guardian: ______________________ Date: ______________