

Rainbow Trail Lutheran Camp

2009 Health History & Examination Form

BRIDGING BORDERS CAMP DATES: _____
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**** This side must be completed by parent/guardian of minors within 6 months prior to arrival at camp. Please notify Rainbow Trail in writing of any changes in this information between the time this form is completed and camp attendance. ****

PLEASE PRINT

Name _____ Birthdate _____ Age _____ Sex _____
 last first initial

Parent or Guardian (or spouse) _____ Home Phone: (____) _____

Home Address/City/State/Zip _____ Work Phone: (____) _____

Email: _____

If not available in an emergency, notify _____ Relationship _____

Address/City/State/Zip _____ Phone: (____) _____

Do you carry medical/hospital insurance? _____ If so, please indicate:
 Carrier _____ Group/policy number _____

Name and phone number of dentist/orthodontist _____

Describe any emotional, learning, or psychological concerns and provide information to help us work effectively with this camper:

For minor females: Has this person menstruated? ___ If not, has she been told about it? ___ If yes, is menstrual history normal? ___

CHRONIC CONCERNS

- ___ None
- ___ Frequent ear infections
- ___ Heart disease/defect
- ___ Diabetes
- ___ Bleeding/clotting disorders
- ___ Hypertension
- ___ Asthma/Reactive Airway Disease
- ___ Seizures/Convulsions
- ___ Cerebral Palsy
- ___ Other _____

Provide information on each item checked:

DISEASES: (Date any that the camper has had)

- | | |
|-------------------|--------------------|
| ___ Chicken pox | ___ German Measles |
| ___ Mumps | ___ Hepatitis A |
| ___ Measles | ___ Hepatitis B |
| ___ Mononucleosis | ___ Hepatitis C |

Describe any major illness, injury or surgery this camper has had in the past 2 years. _____

ALLERGIES

- ___ No known allergies
- ___ Medications _____
- ___ Insect Stings _____
- ___ Foods _____
- ___ Other: _____

Describe reaction and management to any listed above:

MEDICATIONS

****Bring to camp in original container****

List all medication (including vitamins) bringing to camp:

Name of medication _____
 Reason for taking _____
 Dosage _____
 How often _____ Time of Day _____

Name of medication _____
 Reason for taking _____
 Dosage _____
 How often _____ Time of Day _____

FOR MORE MEDS, ATTACH ADDITIONAL SHEET

My child has permission to participate in all camp activities, except as noted. I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests and treatment for the health of my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize or secure proper treatment (including surgery, injection, and/or anesthesia) for my child as named above.

Parent/Guardian signature _____ Date _____

Signature of witness _____ Date _____

Camper's signature _____ Date _____

**** PHYSICIAN MUST COMPLETE THE BACK OF THIS FORM AND SIGN WITHIN 24 MONTHS OF CAMP DATE ****

PLEASE KEEP A COPY OF THIS FORM

