

NAME:	SPECIAL INFO:	<i>LRCC Office Use Only in this Box:</i>	PROGRAM:	CABIN:
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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 CAMPER MUST HAVE A PHYSICIAN'S EXAMINATION WITHIN TWO YEARS PRIOR TO COMING TO AN LRCC PROGRAM.**

Yolijwa 39136 Harris Rd. Oak Glen, CA 92399 (909) 797-9183
 El Camino Pines 11900 Frontier Rd. Frazier Park, CA 93225 (661) 245-3519

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?	<input type="checkbox"/>	<input type="checkbox"/>	11. Have an orthodontic appliance being brought to camp?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	12. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	13. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	14. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	15. Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	16. Sleepwalk?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	17. Have a history of bedwetting?	<input type="checkbox"/>	<input type="checkbox"/>
8. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	18. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have emotional difficulties?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>			

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
<input type="checkbox"/> Tylenol _____	_____
<input type="checkbox"/> Ibuprofen _____	_____
<input type="checkbox"/> Decongestants _____	_____
<input type="checkbox"/> Antihistamines _____	_____
<input type="checkbox"/> Tums/Roloids _____	_____
<input type="checkbox"/> Pepto Bismol _____	_____
<input type="checkbox"/> Hydrocortisone Cream _____	_____
<input type="checkbox"/> Caladryl _____	_____
<input type="checkbox"/> Midol _____	_____
<input type="checkbox"/> Other _____	_____
<input type="checkbox"/> Other _____	_____
<input type="checkbox"/> 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.