

# 2011 LUTHERAN VALLEY RETREAT CONTACT AND HEALTH HISTORY FORM

Dates of Camp Session \_\_\_\_\_

Name \_\_\_\_\_

Birthdate \_\_\_\_\_ Circle M/F

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Parent Name \_\_\_\_\_

Home Phone Number \_\_\_\_\_

Place of Employment \_\_\_\_\_

Work Phone \_\_\_\_\_

E-Mail \_\_\_\_\_

Cell Phone \_\_\_\_\_

Parent Name \_\_\_\_\_

Home Phone Number \_\_\_\_\_

Place of Employment \_\_\_\_\_

Work Phone \_\_\_\_\_

E-Mail \_\_\_\_\_

Cell Phone \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_

Relationship to Camper \_\_\_\_\_

Emergency Contact Address \_\_\_\_\_

Emergency Contact Phone \_\_\_\_\_

Family Medical Insurance Company \_\_\_\_\_

Insurance Phone \_\_\_\_\_

Insurance Address \_\_\_\_\_

Insurance City/State/Zip \_\_\_\_\_

## Parent Permission & Endorsement

This health history is correct so far as I know & the child herein described has permission to engage in all prescribed activities including, without limitation, climbing/rappelling, equine, low and high ropes courses, rafting, and walking or riding in camp vehicles, except \_\_\_\_\_.

I understand that many of these activities are limited to 11 year and older youth. I hereby assume the risk of all injuries to the person herein described & I release and discharge Lutheran Valley Retreat, its agents and employees from any and all liability that results from injury to the person herein described. Insurance protection is my responsibility.

I give permission for the camp to administer medications as it deems necessary to this child, including medications sent with my child or nonprescription medications available at camp. In the case of an emergency, I know every effort will be made to contact me. In the event I cannot be reached, I hereby give my permission for the medic selected by the camp director to hospitalize and secure proper treatment for my child.

I assume financial responsibility for actions that may cause damage to property.

If the staff deems it necessary for my child to be removed from camp, due to disciplinary or other problems I will respond by promptly picking up my child from camp.

Signature of Parent/Guardian \_\_\_\_\_

Date \_\_\_\_\_

Lutheran Valley Retreat requires every camper to have a physical within 12 months prior to their camp session; doctor may sign a photocopy of this form, but all signatures must be original and include camper's name.

**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **Blood Pressure:** \_\_\_\_\_

**Current Medication: Please not, all prescription MUST be prescribed to this individual, within expiration date, and in their original packaging**

Name of Medication	Reason for taking	Dosage	Schedule

**Health History**

Condition	Circle one	If Yes:	Condition	Circle one	If Yes:	Condition	Circle one	If Yes:	Condition	Circle one	If Yes:	Conditions	Circle one	If Yes:
Anxiety or depression	No Yes	Current Past	Recurrent Headaches	No Yes	Current Past	Heart Disease or problems	No Yes	Current Past	Diabetes	No Yes	Current Past	ADD or ADHD	No Yes	Current Past
Epilepsy	No Yes	Current Past	Asthma	No Yes	Current Past	Frequent Colds	No Yes	Current Past	Frequent Ear Infections	No Yes	Current Past	Bed Wetting	No Yes	Current Past
Ear, Nose, or Throat Trouble	No Yes	Current Past	Disease or injury to joints or back	No Yes	Current Past	Stomach or intestine trouble	No Yes	Current Past	Dizzy Spells or Fainting	No Yes	Current Past	Home Sickness	No Yes	Current Past
Eating Disorders	No Yes	Current Past	Comments, other issues, physical limitations and/or list surgeries											

**Allergies/Dietary Needs**

Type of Allergy	Circle	Describe/Specify Allergen	Mild (runny nose, sneezing)	Moderate (Swelling or severe rash)	Severe (System Response/Difficulty breathing)
Food	No Yes				
Medication	No Yes				
Environmental (animal, insect, etc.)	No Yes				
Other	No Yes				
Vegetarian? No Yes Limitations:		Gluten Allergy? No Yes Limitations:		Lactose Intolerant? No Yes Limitations:	

**Immunizations**

Vaccination	Most Recent Date	Vaccination	Most Recent Date	Vaccination	Most Recent Date	Vaccination	Most Recent Date	Vaccination	Most Recent Date
Measles, Mumps, Rubella (MMR)		Hepatitis A		HIB		Chicken Pox (or had the disease)		Influenza	
Diphtheria/Tetanus (DPT)		Hepatitis B		Polio		Other		Other	

I have examined and found camper to be in satisfactory physical condition, free from any contagious disease and capable of active participation in a regular camp program at altitudes of 8,400-9,100 feet above seal level except as follows \_\_\_\_\_

The camper is under the care of a physician for the following condition(s): \_\_\_\_\_

Licensed Physician's Signature \_\_\_\_\_ Date of Examination \_\_\_\_\_

Doctor Name \_\_\_\_\_ Doctor Phone \_\_\_\_\_

Doctor Address \_\_\_\_\_

Doctor City/State/Zip \_\_\_\_\_

**Official Use only (camp staff only to be determined on site): The camper appears to be healthy and free of contagious disease and capable of active participation for all camp activities. Circle one Yes No**