

Heit's Point Lutheran Ministries Health Form

This form must be on file with Heit's Point prior to participation in any programming.

Camper Last Name _____ First Name _____ Date of Birth _____

Gender M () F () Height _____ inches, Weight _____ lbs

Address _____ City/State/Zip _____

Mother's Name _____ Day Phone _____ Night Phone _____ Lives with camper: _____

Father's Name _____ Day Phone _____ Night Phone _____ Lives with camper: _____

Emergency Contact Name _____ Relationship to camper _____

Day Phone _____ Night Phone _____ In case of emergency, whom should we call first: _____

Name of Medication	Reason for Taking	Dosage	Schedule

Health History

Condition	Circle one	If You:	Condition	Circle one	If You:	Condition	Circle one	If you:	Condition	Circle one	If you:	Condition	Circle one	If you:
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 or Convulsions	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 one	Describe/Specify Allergen	Mild (Runny nose, sneezing)	Moderate (Swelling / severe rash)	Severe (Systemic Response/Difficulty breathing)
Food	Yes No				
Medication	Yes No				
Environmental (animal, plant, insect, etc.)	Yes No				
Other	Yes No				
Vegetarian	Yes No	Limitations:	Gluten Free	Yes No	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)		Influenza		
Diphtheria/Tetanus (DPT)		Hepatitis B		Polio		Other		Other		
Date of last Physical Exam:		Physician Name:				Physician Phone:				
Consent for Medication We will call and Verify with parent/guardian If the situation arises.	Acetaminophen (i.e. Tylenol) For mild fevers and discomforts		Yes No	Throat Lozenges For coughs or sore throats		Yes No	Cough/Cold Medicine (i.e. Sudafed, Nyquil) For allergy symptoms / colds			Yes No
	Ibuprofen (i.e. Advil, Motrin) For mild fevers, discomforts, and Inflammation		Yes No	Creams (i.e. Calamine, Aloe Vera) For itching, sunburn, insect bites		Yes No	Antacids (i.e. Pepto Bismol, Tums) For upset stomachs or heart burn			Yes No
	Aspirin (i.e. Bayer) For mild fevers and discomforts		Yes No	Allergy Medications (i.e. Benadryl) For allergy symptoms		Yes No	Antidiarrhea (i.e. Imodium, Kaopectate)			Yes No

Medical Insurance: Do you have medical insurance? Yes No ***If yes please attach a copy of both the front and back of your health insurance card.**

Authorization

I hereby give informed and expressed consent for this individual to take part in all camp activities under supervision, and agree that the camp or camp personnel will not be held responsible for accidents arising there from. I authorize the camp Health Care Provider and/or designated camp staff to provide appropriate treatment to this individual for injuries and/or illness. This includes, but is not limited to, following Heit's Point medical procedures and protocols, following poison control recommendations, administering prescription medications as noted above, administering over the counter medications as approved above, transportation to hospital care, and following directions from the medical director. I understand that the information on this form may be released to the appropriate medical personnel in case of emergency. I agree to pay any cost for medical care in the event of an emergency, even if I do not have health insurance coverage or not all costs are covered by insurance. I also understand that failure to disclose medical or emotional problems in advance may lead to serious consequences while at camp. Lastly, I verify that everything contained on this form is complete and accurate, to the best of my knowledge.

Parent/Guardian Signature or Participant Signature if over 18: _____ Date _____