

**CAMPER HEALTH HISTORY FORM p.1**

Mail this form to  
FLLC two (2) weeks  
prior to attendance

Dates will attend camp: from \_\_\_\_\_ to \_\_\_\_\_ Birth date: \_\_\_\_\_ Age when at camp: \_\_\_\_\_  
Month/Day/Year Month/Day/Year  
 \_\_\_ Male or \_\_\_ Female Camper Name: \_\_\_\_\_  
First Middle Last

**To Parent(s)/Guardian(s): Please follow the instructions below. Attach additional information if needed.**  
 1) Complete all pages of this FORM and make a COPY.  
 2) Send the original, signed FORM to camp by the requested date. Keep a copy for yourself.

Camper Home Address: \_\_\_\_\_  
Street Address City State Zip Code

Parent/Guardian with legal custody to be contacted in case of illness or injury: Email: \_\_\_\_\_  
 Name: \_\_\_\_\_ Relationship to camper: \_\_\_\_\_ Preferred Phone: ( ) \_\_\_\_\_

Home Address: \_\_\_\_\_  
(if different from above) Street Address City State Zip code

Other emergency contact information (Work, second parent/guardian, etc.):  
 Name: \_\_\_\_\_ Relationship to camper: \_\_\_\_\_ Preferred Phone: ( ) \_\_\_\_\_

**RELEASE NAMES: This child is allowed to be release to the following people (please list):**

**\*\* This child is NOT ALLOWED release to the following people:** \_\_\_\_\_  
(Attach additional information/explanation, if needed.)

**Allergies:** \_\_\_ No known allergies, or \_\_\_ This camper is allergic to: \_\_\_ Food, \_\_\_ Medicine, \_\_\_ The environment, \_\_\_ Other  
(Please describe below what the camper is allergic to and the reaction seen. Attach additional information if needed.)

**Diet, Nutrition:** \_\_\_ This camper eats a regular diet. \_\_\_ This camper eats a regular *vegetarian* diet.  
 \_\_\_ This camper has special food needs. (Please describe below. Attach additional information, if needed.)

**Restrictions:** \_\_\_ I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.  
 \_\_\_ I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations: (Please describe below. Attach additional information, if needed.)

**Medical Insurance:**  
 This camper is covered by family medical/hospital insurance: \_\_\_ YES, or \_\_\_ NO  
 Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.  
 Insurance company: \_\_\_\_\_ Policy Number: \_\_\_\_\_  
 Subscriber: \_\_\_\_\_ Insurance Company Phone Number: ( ) \_\_\_\_\_  
 CAMPER is aware of his/her own health needs: \_\_\_ YES, or \_\_\_ NO

**Parent/Guardian Authorization for Health Care and FLLC Public Relations:**  
 This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the camp health officer for treatment and to refer further treatment to a physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status. I retain the responsibility for any and all bodily injury, loss or damage of property. I also hereby grant permission for Fortune Lake Lutheran Camp this camper's likeness in photos and quotes for future publicity.  
 Signature of Custodial  
 Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to camper: \_\_\_\_\_  
 Signature of Camper: \_\_\_\_\_ Date: \_\_\_\_\_

Camper Name: \_\_\_\_\_  
First Middle Last  
 (For Camp Use) Program, Cabin & Counselor: \_\_\_\_\_

**CAMPER HEALTH HISTORY FORM p.2**

Birth date: \_\_\_\_\_ Camper Name: \_\_\_\_\_  
First Middle Last

**Immunization History:** Provide the month and year for each immunization. Starred (\*) immunizations must be current. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

Diphtheria, tetanus, pertussis\*: \_\_\_\_\_ Tetanus Booster\*: \_\_\_\_\_  
Polio (IPV)\*: \_\_\_\_\_ Mumps, Measles, Rubella\*: \_\_\_\_\_  
Haemophilus influenza type B (HIB): \_\_\_\_\_ Chicken Pox: \_\_\_\_\_ or had: \_\_\_\_\_  
Pneumococcal (PCV): \_\_\_\_\_ Hepatitis A: \_\_\_\_\_  
Hepatitis B: \_\_\_\_\_ Has Hepatitis C\*: \_\_\_YES, or \_\_\_NO  
Tuberculosis (TB) Test: \_\_\_\_\_ ( \_\_\_ negative, or \_\_\_ positive) OTHER: \_\_\_\_\_

**If your camper has not been fully immunized, please sign the following statement: I understand and accept the risks to my child from not being fully immunized.**

Signature of Custodial Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_

**Mental, Emotional, and Social Health: Check "Yes" or "No" for each statement.**

Has the camper :

- 1) Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? \_\_\_ Yes, or \_\_\_ No
- 2) Ever been treated for emotional or behavioral difficulties or an eating disorder?..... \_\_\_ Yes, or \_\_\_ No
- 3) During the past 12 months, seen a professional to address mental/emotional health concerns?..... \_\_\_ Yes, or \_\_\_ No
- 4) Had a significant life event that continues to affect the camper's life? ..... \_\_\_ Yes, or \_\_\_ No

(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

**Please explain "Yes" answers in the space below or please attach a note,** noting the section and question.

The camp may contact you for additional information.

**Medication:** \_\_\_ This camper will not take any daily medications while attending camp.  
\_\_\_ This camper **WILL TAKE** the following daily medications while at camp. (**Show medication & daily instructions**)  
\*\*Attach an additional note, if needed and note the specific section you are answering.

**\* All prescriptions and over the counter medicines (even vitamins & natural remedies) need to be listed, and are required to be in original pharmacy containers with labels.** Please provide enough of each medication to last the entire time the camper will be at camp.

**General Health History: Check "Yes" or "No" for each statement. If "Yes", please attach an explanation and note the question.**

Has/does the camper:

Ever been hospitalized?..... ___ Yes, or ___ No	Ever had surgery?..... ___ Yes, or ___ No
Have recurrent/chronic illnesses?..... ___ Yes, or ___ No	Had a recent infectious disease?..... ___ Yes, or ___ No
Had a recent injury?..... ___ Yes, or ___ No	Had asthma/wheezing/shortness of breath?..... ___ Yes, or ___ No
Have diabetes?..... ___ Yes, or ___ No	Had seizures?..... ___ Yes, or ___ No
Had headaches?..... ___ Yes, or ___ No	Had fainting or dizziness?..... ___ Yes, or ___ No
Ever had back/joint problems?..... ___ Yes, or ___ No	Passed out/had chest pain during exercise?..... ___ Yes, or ___ No
Have a history of bedwetting?..... ___ Yes, or ___ No	Had "mono" during the past 12 months?..... ___ Yes, or ___ No
Have any skin problems?..... ___ Yes, or ___ No	If female, any problems w/ periods/menstruation? ___ Yes, or ___ No
Problems w/ diarrhea/constipation?... ___ Yes, or ___ No	Have problems w/ falling asleep/sleepwalking?..... ___ Yes, or ___ No
Wear glasses, contacts or other?..... ___ Yes, or ___ No	Traveled outside the country in past 9 months?..... ___ Yes, or ___ No
Had appendicitis?..... ___ Yes, or ___ No	Has Hypertension?..... ___ Yes, or ___ No
Has sinus infection/chronic sinusitis? ___ Yes, or ___ No	Has ear trouble?..... ___ Yes, or ___ No
Has Hay Fever?..... ___ Yes, or ___ No	Has tonsillitis?..... ___ Yes, or ___ No
Has ulcers?..... ___ Yes, or ___ No	Had/has whooping cough?..... ___ Yes, or ___ No

Name of camper's primary doctor(s): \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Name of dentist(s)/orthodontist(s): \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Signature of Custodial Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_

**Have we forgotten anything? If so, please attach any other pertinent information. THANK YOU!**