Voyageurs Lutheran Ministry Health Form

Please print clearly. This form will be copied. Use a separate form for each camper.
Health information on this form is gathered to assist us in identifying appropriate care.
This form should be returned to the camp office by June 1.

Camper Name _____ Date / Camp attending _____

Gender _____ Birthdate _____ Age _____ Grade completed _____

Camper Address _____
City/State/Zip _____
Home Phone _____
Parent/Guardian _____
Parent work phone _____
Cell phone _____

Second Parent/Guardian _____
Home phone (if different) _____
Work phone _____
Cell phone _____
Emergency Contact Person _____
Phone _____

Allergies: *(check those which apply to this camper)*

____ This camper has no known allergies
____ This camper has an allergy to the following food(s): _____
Describe the reaction if this food is eaten and what is done to manage it: _____
_____
____ This camper is allergic to the following medication(s): _____
_____
____ This camper is allergic to the following: _____
Describe the reaction and what is done to manage it: _____
_____

Diet: *Check those which apply to this camper. We will work meet any medical dietary restrictions but cannot cater to individual food preferences. Please call if you have a question about diet.*

____ This camper eats a regular, varied diet.
____ This camper eats this type of diet:
__ Gluten free
__ Dairy Free
__ Semi-vegetarian (no beef or pork)
__ Vegetarian (no meat)
__ Vegan (no meat, eggs or dairy)
__ Other _____

Medication: *Provide complete information. Bring enough medication to last the entire session.* ***ALL*** *medication* ***MUST*** *be in original pharmacy containers and appropriately labeled.*

____ This camper does not take routine medication.
____ This camper takes routine medication (including vitamins) as follows (attach more information if needed):

Name of medication _____ Name of medication _____
Reason for taking _____ Reason for taking _____
Dosage _____ Dosage _____
When med is taken _____ When med is taken _____

The following medications (or generic equivalents) are on hand in our Health Center. They are used and dispensed as directed by our medical protocols. *Cross out those which your child should* ***not*** *be given.*

Acetaminophen	*Benadryl tablets*	*Benadryl Cream*	*Ibuprofen*
Cough drops	*Alka-Seltzer*	*Tums*	*Cough Suppressant*
Cold/Sinus Medicine	*Eye drops*	*Chewable Tylenol*	*Children's Tylenol Cold*
Desitin Cream	*Aloe*	*Triple Antibiotic Cream*	*Hydrocortisone Cream*

Immunizations: *(please provide the month and year)*

_____ DPT Permanent Shots (series of 3)
_____ Tetanus Booster
_____ Polio Immunization
_____ MMR (Measles, Mumps, Rubella)
_____ Hepatitis B
_____ Haemophilus influenza b (Hib)

Swimming Ability:

____ Non-swimmer
____ Beginner - minimal swimming skills; avoids deep water
____ Intermediate - comfortable in deep water

General History: *Circle "yes" or "no" for each statement*

Has/does the camper:

Have asthma/wheezing/shortness of breath? yes no
Have diabetes? yes no
Had seizures? yes no
Have headaches/migraines? yes no
Have frequent ear infections? yes no
Had chicken pox? yes no
Had mononucleosis in the past 12 months? yes no

For girls: knows about menstruation and/or has a normal menstrual history……yes no

Have difficulty hearing? yes no
Have problems with falling asleep/sleepwalking? yes no
Have a history of bedwetting? yes no
Typically make noises while sleeping?(snores, talks, etc) yes no
Usually get up an night to use the bathroom? yes no
Wear glasses, contacts or protective eyewear? yes no
Recently been taken off a medication? yes no

Please explain "YES" answers in the space below.

Restrictions:

_____ I have reviewed the program and activities of the camp and feel my child can participate without restrictions.

_____ I have reviewed the program and activities of the camp and feel my child can participate with the following restrictions or adaptations: (**Please describe below)**

What have we forgotten to ask? *Provide additional information about your child's health which may have been neglected on this form. Also, if there are life events or other things of which our staff should be aware regarding your child, please include them here.*

Name of Family Doctor _____ Phone _____

Insurance Information: In the event that your child needs to be seen by someone other than our Health Care Manager, it is helpful for us to have insurance information to pass on to the treating hospital or clinic.

Insurance Company _____ Policy number _____

My child has permission to participate in all aspects of the program at Voyageurs Lutheran Ministry except as noted. I hereby give my permission to the physician selected by Voyageurs Lutheran Ministry to secure proper treatment, to hospitalize, to order injection, anesthesia, x-ray or surgery for my child as named above. Voyageurs Lutheran Ministry will make every effort to contact me if my child needs emergency medical-surgical treatment. I understand that my insurance has primary coverage and Voyageurs Lutheran Ministry insurance is secondary. I also give permission for any picture take of my child to be used for promotional purposes, including the VLM website, Facebook page, and Instagram account.

Parent or Guardian signature _____ date _____