Lutheran Outdoor Ministries of Florida
Camper Health History Form

MANDATORY!! This form MUST be returned **3 WEEKS prior to camp start date!**

Health history must be filled out by parent or custodial guardians. **Update required annually.** Health exam (back page) must be completed by an approved licensed medical professional at least every two years. For additional comments/information, please attach separate paper.

Camper Name______________________________________ Birth Date ____________ Gender ________
Last First Middle

Custodial Parent/Guardian ______________________________________ Phone # ________________

Name of Family Physician ______________________________________ Phone # ________________

Address of Family Physician ____

- THIS HEALTH HISTORY IS CORRECT AND COMPLETE AS FAR AS I KNOW.
- THE PERSON HEREIN DESCRIBED HAS PERMISSION TO ENGAGE IN ALL CAMP ACTIVITIES EXCEPT AS NOTED.

I hereby give permission to Lutheran Outdoor Ministries of Florida to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child.
In the event I cannot be reached in an emergency, I hereby give permission to the Health Care provider selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent or custodial guardian ____

Printed Name ____ Date ____________________

Health History

The parent or custodial guardian must complete the following information. The intent of this information is to provide the LOMF camp healthcare personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon camper's arrival to camp. Provide complete information so that the camp is aware of your needs.

ALLERGIES List all known. Describe reaction and management of the reaction, if known.
Medication allergies (list)

______________________________ ____

Food Allergies (list all known)

______________________________ ____

Other allergies (list) – *include insect stings, hay fever, asthma, animal dander, etc.*

______________________________ ____

RESTRICTIONS

The following restrictions apply to this individual:
Dietary

- ☐ Does not eat red meat
- ☐ Does not eat pork
- ☐ Does not eat eggs
- ☐ Does not eat poultry
- ☐ Does not eat seafood
- ☐ Does not eat dairy products
- ☐ Other (describe)

____

Explain any restrictions to activity (e.g. what cannot be done, what limitations/adaptations are necessary)

____

GENERAL HEALTH QUESTIONS

Has/does the participant:

	Yes	No
Had **recent** injury, illness or diseases?	☐	☐
Have a **chronic** or recurring illness/condition?	☐	☐
Have frequent **headaches**?	☐	☐
Have **diabetes**?	☐	☐
Have **asthma**?	☐	☐
Had **mononucleosis** in the past 12 months?	☐	☐
If female, have abnormal **menstrual** history?	☐	☐
Ever had an **eating** disorder?	☐	☐

Please explain any "yes" answers, noting the **key word** in the question (use additional paper if necessary).

____

MEDICATION

Please list **ALL** medications being taken by camper, including over-the-counter or nonprescription drugs. Bring enough medication to last the entire time at camp. **Keep ALL medications in their original packaging/bottle** with clear dosage and frequency instructions, name of medication, and prescribing physician if a prescription drug.

☐ This person takes NO medications on a routine basis.

☐ This person takes medications as follows:

Med #1 ______________________ Dosage __________ Specific times taken each day __________

Reason for taking ____

Med #2 ______________________ Dosage __________ Specific times taken each day __________

Reason for taking ____

Attach additional pages for more medications if needed.
Also, please list meds taken during school year not taken during the summer.

Infectious Disease

☐ No exposures in last three weeks

Exposed to:

__ Chicken pox __ Measles
__ Mumps __ Hepatitis, type ___
__ Rubella

If exposed, has camper had disease previously or been immunized against it?

☐ **Yes, specify** _______________ ☐ **No** ☐ **Unknown**

Immunization Screen

Immunization Screen	Yes	No	Unknown
Influenza (within last year)	☐	☐	☐
Pneumovax (within last 5 years)	☐	☐	☐
Tetanus (within last 10 years)	☐	☐	☐
Hepatitis B series (completed)	☐	☐	☐

INSURANCE INFORMATION

Is the participant covered by family medical/hospital insurance? ☐ Yes ☐ No

If so, indicate carrier or plan name ______________________________ Group # ____________

Health Care Recommendations by Licensed Medical Personnel

PLEASE NOTE: A SPECIAL VISIT TO YOUR PHYSICIAN IS **NOT** NECESSARILY REQUIRED. YOUR PHYSICIAN SHOULD SIGN THIS FORM, VERIFYING A PHYSICAL EXAM **WITHIN 24 MONTHS OF YOUR CAMP**.

I examined this individual on ________________ (date). Requirements specify exams occur within 24 months of camp attendance. A new exam may not necessarily be required for camp attendance.

BP ________ Weight ________ Height _________

The applicant is under the care of a physician for the following condition(s).

____

In my opinion, the above applicant ☐ **is** ☐ **is not** able to participate in an active camp program.

Physician or other Medical Professional Certification (signature & printed name, credentials, and complete address below):

Signature: ______________________________

Printed Name: ______________________________

Address: ______________________________

Phone/Fax #: ______________________________