

Camp Omega Health History Form

Camp Session Name & Date _____

Name _____ Birthdate _____ Sex _____ Age _____

Parent or Guardian (or Spouse): _____

Home Address _____ City _____ State _____ Zip _____ Phone _____

Business Address _____ City _____ State _____ Zip _____ Phone _____

Emergency Contact: _____

Home Address _____ City _____ State _____ Zip _____ Phone _____

Family Physician: _____ Phone _____ Dentist: _____ Phone _____

Medical Insurance: _____ Address: _____ Insured Name: _____

Medications Being Taken: List all meds. (including over-the counter) taken routinely. Bring enough in original packaging with complete instructions for entire camp period.

Med. #1 _____ Dosage _____ Times taken each day _____ Med. #2 _____ Dosage _____ Times taken each day _____

Allergies Please list all medication, food and other allergies. If you need additional room please attach.

Allergy: _____ Reaction and management: _____

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Restrictions: Does not eat: Red Meat Pork Dairy Products Poultry Eggs Other _____

Explain any activity restrictions or limitations: _____

Information about participant's behavior, physical, emotional, or mental health about which the camp should be aware:

_____ (attach additional info. if needed)

Immunization History Please record the immunization date

Vaccine	date	date	date	date	date	date
DPT						
TD (tetanus/diphtheria)						
Polio						
MMR						
Or Measles						
Or Mumps						
Or Rubella						
Haemophilus influenza B						
Hepatitis B						
Varicella (chicken pox)						

General Questions (explain "yes" below)	Yes	No
1. Recent injury or illness?	<input type="checkbox"/>	<input type="checkbox"/>
2. Chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever had seizures	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
7. If female, have an abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have a history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>
10. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>
12. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
Please explain any "yes" answers: _____		

Important - This box must be completed for attendance

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted. **Authorization for Treatment:** I hereby give permission to the medical personnel selected by the camp director to provide routine health care; to administer medications; order x-rays, routine tests, treatment, to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. The completed forms may be photocopied for trips out of camp.

★ **Signature** of parent or guardian or adult guest/staff _____ **Date** _____

Photo Release: I give permission and consent to allow photographs, videotapes, and interviews to be taken during the camp session. I further give consent that any such images or interviews may be published and used to illustrate and promote the camp and the National Lutheran Outdoors Ministry Association. ★ **Signed** (parent, guardian or adult camper/staffer) _____

For Camp Use - In-Camp Health Screening Record Date of screening _____ Time _____ Conducted by _____

Meds Received at Screening _____

Updates / Additions to health history noted [] Yes [] No [] None Required

Current Health Needs Identified: _____

Observational Notes _____