

Health History Form

2010 Summer Camp

Caroline Furnace Lutheran Camp & Retreat Center

2239 Camp Roosevelt Road, Fort Valley, VA 22652 ~ 540-933-6266 (ph) ~ 540-933-6971 (fax) ~ info@CarolineFurnace.org

***Please MAIL this form no later than THREE (3) WEEKS prior to their camp date, properly signed in all places.**

Name: _____ Date of Birth: _____
Home phone: _____ Camp Dates : _____
Address: _____

Parent / Guardian (primary contact) Name: _____ Work phone: _____ Cell phone: _____ Email: _____
--

Parent/Guardian Name: _____ Work phone: _____ Cell phone: _____ Email: _____
--

Emergency contact (if parents can't be reached): _____ phone: _____

Insurance Information:

Company Name _____
Policy # _____ Company Phone: _____
Holder's Name _____ Holder's S.S. # _____
Holder's Address: _____

Activity Restriction(s), if any: _____

Past Medical History: Chronic Illness, Operations, or Serious Injuries:

Dietary Restrictions: _____

Swimming Ability: ___ Non Swimmer ___ Avoids deep water ___ Comfortable in deep water

Behavioral History: ___ Homesick ___ Constipation ___ Bedwetting

For Females:

Has this person menstruated? Y / N

If not, has she been told about it? Y / N

If so, is her menstrual history normal? Y / N

Additional Comments or concerns: _____

This health history is correct as far as I know, and my child has permission to engage in all camp activities, except as noted. In the event that I cannot be reached in an emergency, I give permission to medical personnel and/or the physician selected by the camp directors to hospitalize, secure proper medical treatment for and to order injections, anesthesia, x-rays, routine tests, or surgery' to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child as named above. This form may be photocopied for trips out of camp

Signature of Parent/Guardian _____ Date: _____

Health History

<input type="checkbox"/> ADD	<input type="checkbox"/> Anorexia/Bulimia
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Chicken Pox
<input type="checkbox"/> Depression	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Freq. Ear Infections
<input type="checkbox"/> Headaches	<input type="checkbox"/> Measles
<input type="checkbox"/> Menstrual cramps	<input type="checkbox"/> Mumps
<input type="checkbox"/> Sleepwalking	
<input type="checkbox"/> Seizures (describe) _____	
<input type="checkbox"/> Heart problems (describe) _____	

Allergies:

Hay Fever

Poison Ivy

Insect Stings

Penicillin

Asthma (Inhaler? Y /N)

Other drugs _____

Food Products _____

Physical Examination

To be completed by a Licensed Physician or attach a copy of any current physical exam within the past 24 months

I have examined _____ Date examined: _____

Vital Statistics: Height _____ Weight _____ Blood Pressure _____
Pulse Rate _____ Breathes/min at rest _____ Temperature _____

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

Current treatment (including current medications) _____

Recommendations and Restrictions while at Camp:

Any treatment to be continued at camp: _____

Activities to be encouraged or restricted: _____

Additional health information: _____

Immunizations: (dates)

<input type="checkbox"/> DPT Permanent Shots (Series of 3)	<input type="checkbox"/> Tetanus Toxioid Booster
<input type="checkbox"/> Polio Immunization	<input type="checkbox"/> Tuberculin
<input type="checkbox"/> MMR (Mumps, Measles, Rubella)	<input type="checkbox"/> Other _____

Physician Address _____ Phone: _____

Date of form completion: _____ Name (please print) _____

Licensed Physician signature: _____