YOUTH HEALTH FORM

General Information

Camp Program Attending: _____ *Program Date:* _____

Complete health form online or mail paper version to camp at least 2 weeks prior to arrival. Sponsored retreats may submit to the group leader.

Before you begin, please make sure you have the following information for each child you are registering.

- *Medication Instructions or Allergy Information (if any)*
- *Immunization Record (Vaccinations and/or Boosters)*
- *Family Doctor & Insurance Information*

Medical information must be provided for your child to attend camp. It is essential for the camp to have your child's current health information, in order to be able to ensure the safety and well-being of campers during their time at camp.

Camper Information

Camper First Name: _____ *Camper Last Name:* _____

Camper Address: _____ *City:* _____ *State:* _____ *Zip:* _____

Camper Address Same as Parent *Yes* *No* *Camper Birthdate:* _____ *Camper Gender:* _____

Parent Address: _____ *City:* _____ *State:* _____ *Zip:* _____

Home Phone: _____ *Cell Phone:* _____ *Work Phone:* _____

In case of an emergency and parent/guardian is unavailable, please notify:

Name: _____ *Relationship:* _____ *Phone:* _____

Name: _____ *Relationship:* _____ *Phone:* _____

Allergies and Dietary Restrictions

Does your child have any allergies? *Yes* *No*

Allergy Type(s): _____ *Allergic to:* _____

Allergic reaction details, date and descriptions:

_____

_____

Does your child require an EpiPen? *Yes* *No*

Please provide details about your child's anaphylaxis, including the date and description of the reaction:

_____

Does your child have any dietary restrictions? *Yes* *No*

Please provide details about your child's dietary restrictions:

_____

Medications and Treatments

Will your child be taking any medications while at camp? *Yes* *No*

Please explain the reason for the medication and any notes on giving this medication to your child in the spaces below.

Medication (1): _____ *Medication (2):* _____ *Medication (3):* _____

Dose (1): _____ *Dose (2):* _____ *Dose (3):* _____

Morning Lunch Dinner Bedtime Other: _____ ***Morning Lunch Dinner Bedtime Other:*** _____ ***Morning Lunch Dinner Bedtime Other:*** _____

Notes: _____ *Notes:* _____ *Notes:* _____

_____ _____ _____

Will your child require any treatments while at camp? *Yes* *No*

Please explain what treatment(s), including the frequency.

_____

Does your child regularly take any medications that ***will not*** *be taken at camp?* *Yes* *No*

Explain what medications your child takes regularly and why they are taken.

_____

For Office Use:
Counselor: _____ **Cabin:** _____

Child Full Name: _____

Immunizations

Please list the date or confirm your child's most recent vaccination (if any) or booster is up to date for the following:

Tuberculosis (TB)	*Immunized* _____	*Haemophilus Influenza B*	*Immunized* _____
Chicken Pox (Varicella)	*Immunized* _____	*Hepatitis B*	*Immunized* _____
Diptheria, Pertussis, Tetanus (DPT)	*Immunized* _____	*Measles*	*Immunized* _____
Mumps	*Immunized* _____	*Rubella*	*Immunized* _____
Polio Series	*Immunized* _____		

If your child has not been fully immunized, please explain:

_____

Over the Counter Medications

The following over-the-counter medications may be given to your child while at camp. Check all that apply. If there is a preferred or need name brand, please purchase and check-in as medicine.

- ❒ *Ibuprofen*
- ❒ *Acetaminophen*
- ❒ *Cold Formula*
- ❒ *Sore Throat Spray*
- ❒ *Sore Throat Lozenges*
- ❒ *Nasal Decongestant*
- ❒ *Antihistamines*
- ❒ *Diarrhea Aid*
- ❒ *Upset Stomach Aid*
- ❒ *Hydrogen Peroxide*
- ❒ *Betadine/PhisoHex*
- ❒ *Anti-Boitic Ointment*
- ❒ *Zinc Oxide/Noxema/Solarcaine*
- ❒ *Allergy Medication*
- ❒ *Hydro-Cortisone Cream*
- ❒ *Sunscreen*
- ❒ *Insect Repellent*
- ❒ *Itch Relief*
- ❒ *Cough Medicine*
- ❒ *Sting Swabs*
- ❒ *Sunburn Spray*

Health History

Please circle if your child has experienced, or is currently experiencing, any of the following conditions?

ADD/ADHD	*Yes*	*No*	*Ear Infections*	*Yes*	*No*
Asthma/Inhaler	*Yes*	*No*	*Eating Disorder*	*Yes*	*No*
Bedwetting	*Yes*	*No*	*Epilepsy*	*Yes*	*No*
Behavioral Issues	*Yes*	*No*	*Headaches*	*Yes*	*No*
Blackouts/Fainting	*Yes*	*No*	*Homesickness*	*Yes*	*No*
Depression	*Yes*	*No*	*Mental Health Issues*	*Yes*	*No*
Developmental Delays	*Yes*	*No*	*Seizures*	*Yes*	*No*
Diabetes	*Yes*	*No*	*Other* _____		

Please circle based upon your child's health history:

If applicable, has your child begun her menstrual cycle?	*Yes*	*No*
Has your child had any operations?	*Yes*	*No*
Has your child ever been hospitalized or had a serious injury?	*Yes*	*No*
Has your child been exposed to any communicable diseases within the last 3 months?	*Yes*	*No*
Does your child have any restrictions on activities?	*Yes*	*No*
Will your child require any special assistance while at camp?	*Yes*	*No*

If you answered yes to any of the above questions, please describe further here. Please list any other medical information the camp should have about your child. Is there anything you would like to discuss with the camp medical staff?

_____

_____

_____

Be sure to fully explain any conditions your child is currently experiencing and how staff can better assist:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

For Office Use:
Counselor: _____ **Cabin:** _____

Child Full Name: _____

Health Insurance, Physician & Dentist/Orthodontist Information:

Please attach a copy of insurance card

Health Insurance: _____ *Policy #:* _____ *Group #:* _____

Address: _____ *Phone #:* _____ *Person carrying the policy:* _____

Physician: _____ *Phone #:* _____

Dentist: _____ *Phone #:* _____

Camper Checkout:

When the camp session is complete, the following adult(s) will be picking up my child:

Name: _____ *Phone:* _____

Please call the camp office if this name changes prior to the checkout time.

Medical Waiver:

I hereby give permission for the camper, previously named, to receive the over-the-counter and prescribed medications as indicated at the direction and under the supervision of designated Camp Health Center staff.

I hereby give permission for my son/daughter to participate in all camp activities including challenge/ropes course, wall climbing, swimming, kayaking, canoeing, and off site field trips, except as noted. Further, I give permission for use of photos of my child to be used in camp and ELCA promotion unless noted. I have read and agree to the LOMO privacy policies found at lomocamps.org/privacy. My child will follow the rules of the camp and the directions of the camp staff.

I hereby give permission to the medical personnel selected by the camp director to provide routine health care; order x-rays, routine tests, and treatment; to release any records necessary for insurance purposes; and to arrange necessary transportation for 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 child as named above. This completed form may be photocopied for trips out of camp.

_____ _____ _____

Signature of Parent/Legal Guardian ***Printed Name*** ***Date***

For Summer Camps: *Complete online or mail two weeks prior to the camp you're attending.*
For LOMO Sponsored Retreats: *Please give to your congregation's leader.*

Lutheran Memorial Camp
PO Box 8
Fulton, OH 43321
Phone: 419.864.8030
Fax: 419.864.1582
lmc@lomocamps.org

Camp Mowana
2276 Fleming Falls Road
Mansfield, OH 44903
Phone: 419.589.7406
Fax: 419.589.3096
mowana@lomocamps.org

Camp Luther
3901 Lake Road
Conneaut, OH 44030
Phone: 440.224.2196
luther@lomocamps.org

For Camp Office Use Only:

Date of Health Screening: _____ Name of Health Care Provider: _____

Any observable evidence of illness, injury, or communicable disease? Yes No

If Yes, please describe.

_____

_____

_____