CAMP: [ ]NeSoDak [ ] Klein Ranch [ ] Outlaw Ranch [ ] Joy Ranch

Week at Camp:_____ Year:_____ Cabin Group:_____

BRING THIS 2-SIDED FORM WITH YOU TO CAMP!

HEALTH HISTORY FORM

for Children, Youth and Adults Attending Camps at Lutherans Outdoors in South Dakota

NESODAK KLEIN RANCH OUTLAW RANCH JOY RANCH

CAMPER NAME: _____

Camper Name_____DOB____/_____/_____Gender_____Age_____

Parent/Guardian (or Spouse)_____

Current Address_____

Street City State Zip

Day Phone ( )_____ Night( )_____ Cell( )_____

Second Parent/Guardian or Emergency Contact_____

Current Address_____

Street City State Zip

Day Phone ( )_____ Night( )_____ Cell( )_____

HEALTH HISTORY (Check all that apply / Give approximate dates)

_____ Frequent Ear Infections _____ Heart Defect/Disease _____ Convulsions _____ Diabetes
_____ Hypertension _____ Mononucleosis _____ Psychiatric Treatment _____ Bleeding/Clotting Disorder

DISEASES

_____Chicken Pox _____Measles _____German Measles _____Mumps

ALLERGIES (Dates not Needed)

_____Hay Fever _____Ivy Poisoning, etc. _____Insect Stings _____Penicillin
_____Other Drugs _____Asthma _____Other (Specify)_____

Has this camper ever required any psychiatric counseling or hospitalization? Yes No

If Yes, Explain _____

Current treatment & medications_____

Current behavioral plan_____

Past history of treatment, medications and behavioral plans_____

Operations or serious injuries (dates)_____

Disability or chronic or recurring illness _____

Current medications & description (***Please send prescriptions in original bottles with directions on the label and turn into health care personnel.***) _____

Name of dentist / orthodontist _____ Phone _____

Name of family physician _____ Phone _____

Date of last physical examination _____

Do you carry family medical / hospital insurance? Yes No *If so, indicate to the right:*

Carrier:

_____

_____

Street

_____

City State Zip

Policy Holder

_____

Policy/Group #

_____

Certificate #

_____

VACCINES	DATE OF BASIC IMMUNIZATION	DATE OF LAST BOOSTER
Tetanus **important**	/ /	/ /
DTAP (series of 5) (Diphtheria, Tetanus, and Pertussis)	/ /	/ /
TDAP (youth over 10)	/ /	/ /
MMR (series of 2) (Measles, Mumps, Rubella)	/ /	/ /
Varicella (series of 2)	/ /	/ /
Polio (series of 4)	/ /	/ /
Hepatitis B (series of 3)	/ /	/ /
Others	/ /	/ /

RECOMMENDATIONS AND RESTRICTIONS WHILE AT CAMP

Activities to be restricted due to health reason_____

_____

Description of any current physical conditions requiring medication, treatment, special considerations, restrictions while at camp._____

_____

_____

Any over-the-counter medications NOT to be given to camper while at camp_____

Any medically prescribed meal plan or dietary restrictions_____

Any allergies (food, drugs, plants, insects, etc.)_____

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

Special Considerations for health care person to be aware of:_____

Any time health care outside the camp community is needed, parents/guardian will be notified. If you wish to be notified in any other circumstances, please list here_____

_____

FOR YOUTH FEMALES ONLY:

Has this person menstruated? _____ If not, has she been told about it? _____ If so, is her menstrual history normal? _____

PHOTO RELEASE: I willingly agree to allow Lutherans Outdoors, by means of photography and video, to publish photographs and/or video of my me/my child for advertising purposes in all forms of media.

[ ] Yes [ ] No

Signature of parent / guardian / adult camper _____

Date _____/_____/_____

Warning, under South Dakota Law, an equine professional is not liable for any injury or death of a participant in equine activities resulting from the inherent risks of equine activities, pursuant to SD 42-11-2.

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 camp health care personnel to provide routine health care and to administer medications brought to camp; and to the medical personnel selected by the camp director to order X-rays, routine tests, treatment, and necessary 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 my child as named above. The completed forms may be photocopied for trips out of camp.

Signature of parent/guardian or adult camper _____

Date ____/_____/_____

I also understand and agree to abide with the restrictions placed on my camp activities:

Signature of minor _____

Date ____/_____/_____

BRING THIS HEALTH FORM WITH YOU TO CAMP
YOU WILL NOT BE PERMITTED TO REGISTER WITHOUT YOUR HEALTH FORM!