



2008 Camp Health Form

***REQUIRED INFORMATION: EMERGENCY ADDRESSES; AUTHORIZATION SIGNATURE; IMMUNIZATION & HEALTH HISTORY**

Required Information must be completed by Parent/Guardian of Minors.

PLEASE RETURN TO CAMP BY MAY 1ST

Winter (until 5/20) Summer (after 5/20)
 10179 Crosstown Circle P.O. Box 1308
 Eden Prairie, MN 55344 Lake Hubert, MN 56459
 ph: 952.922.2545 ph: 218.963.2339
 f: 952.922.7149 f: 218.963.2447

STATISTICS:

NAME: _____
 AGE: _____ BIRTHDATE: _____ GENDER: MALE FEMALE

*EMERGENCY ADDRESSES

Parent/Guardian: _____
 Home Phone: (_____) _____ Home Fax: (_____) _____
 Home Address: _____ City/State/Zip: _____
 Father's: Business Phone: (_____) _____ Mother's: Business Phone: (_____) _____
 Fax: (_____) _____ Fax: (_____) _____
 Cell: (_____) _____ Cell: (_____) _____

If parent/guardian is not available in an emergency, notify:

1) Name: _____ 2) Name: _____
 Relationship: _____ Relationship: _____
 Home Phone: (_____) _____ Home Phone: (_____) _____
 Business Phone: (_____) _____ Business Phone: (_____) _____
 Cell: (_____) _____ Cell: (_____) _____

CURRENT ESSENTIAL MEDICATIONS OR TREATMENTS:

Does your camper take any medications (please mark one): YES NO

Bring enough medication to last the **ENTIRE** session. All medication **MUST** be in pharmacy container(s) and appropriately labeled (see Parent Handbook).

Medication or Treatment	Dosage	When taken each day?				Reason for taking	Will have at camp?	
		Breakfast	Lunch	Dinner	Other		Yes	No

BILLING INFORMATION FOR HEALTH CARE: Parent/guardians are financially responsible for health care given by an out-of-camp provider for medication, illness, treatment, pre-existing conditions, etc. Please include a copy of an insurance card. Copy both sides so addresses and telephone numbers are readable.

Insurance Company: _____
Insurance Claims Address: _____
Insurance Policy number for your child: _____

IMPORTANT: Please notify the camp if this camper is exposed to any communicable diseases prior to camp attendance.

***AUTHORIZATION (REQUIRES SIGNATURE):**

IMPORTANT – MUST BE COMPLETED FOR ATTENDENCE: The camper listed above has my permission to engage in all Camp Lincoln/Camp Lake Hubert activities and programs whether those take place on or off camp property except as noted on this form and under all terms of the enrollment agreement that I have already received. I agree that my camper is voluntarily participating with the knowledge of the inherent and other risks (both known and unknown) in these activities and programs. My camper and I accept full responsibility for any injury, damage, death or other loss resulting from these risks and/or resulting from my camper's own negligence or other misconduct.

AUTHORIZATION FOR TREATMENT: I hereby give permission to the camp 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 physician selected by the camp to secure and administer treatment including hospitalization, injections, anesthesia or surgery, for the person named above. This completed form may be photocopied. This camp has permission to obtain copies of my child's treatment and health record from any provider who treats my child. I understand that information about my child's health will be shared on a "need to know" basis with camp staff. I will notify the camp in writing of any health related changes between the date of this form and my camper's arrival at camp.

This camp health form is complete to the best of my knowledge and contains no misrepresentations or omissions that might or would affect my child's experience at camp.

***Signature of Parent/Guardian:** _____ **Date:** _____

*IMMUNIZATION & HEALTH HISTORY

Camper's Name: _____

Has participant had or currently have:

- YES NO
- Allergies to foods (explain below)
 - Allergies to any medications (explain below)
 - Any other allergies (explain below)
 - Any chronic recurring conditions (i.e. seizures, ear infections, etc.)
 - Allergies to foods (explain below)
 - Asthma
 - Diabetes
 - Frequent headaches
 - Problems with bed-wetting
 - Problems with sleepwalking
 - Operations or serious injuries (list dates & condition below)
 - Disability or other special needs
 - (Girls) ever menstruated
 - (Girls) if not, has she been told about it
 - (Girls) have menstrual cramps
 - Special Equipment (e.g. ear plugs, braces, retainers)
 - Any special dietary needs (list below)
 - Vegetarian (eats no meat)
 - Piercings (list below)

 - Any conditions or restrictions that effect participation in the program (explain below)

Immunization Dates

Please provide current dates or attach immunization record from your health care provider

- YES NO
- DIP (Diphtheria, Tetanus, Pertussia) _____
 - TD (Tetanus Booster) _____
 - IVP/OPV (Polio) _____
 - MMR (Mumps, Measles, Rubella) _____
 - HepB (Hepatitis B) _____

Has the participant had

- | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|
| YES | NO | YES | NO |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Measles | | Chicken Pox | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| German Measles | | Mumps | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Mononucleosis | | Hepatitis | |

General Questions

REFERENCE:

Name of family physician _____

Office Phone (_____) _____

Name of family dentist/orthodontist _____

Office Phone (_____) _____

What have we forgotten to ask? Provide additional information about your child's health which may have been neglected on this form or that might impact your campers program?

Mental & Emotional Health Information

Does camper have, or ever been diagnosed with:

- YES NO
- ADD/ADHD
 - Eating Disorder (please list type): _____
 - Learning Disorder (please list type): _____
 - Emotional Health Concerns (explain): _____
 - Depression/OCD/Anxiety Disorder (explain): _____
 - In the past year camper has seen a mental health professional?
If yes, please attach a statement that describes the concerns and management plan in the event it may need to be addressed while at camp.

EXPLANATION OF ANY "YES" ANSWERS FROM ABOVE (ATTACH ADDITIONAL SHEETS IF NECESSARY):

2008 MEDICAL EXAMINATION:

A medical examination is encouraged but not required. A copy of an examination form/report completed by a licensed physician and done within 12 months of arrival at camp is sufficient. Please attach a copy of this said health form or have it mailed/faxed directly to the camp office.

2008 HEALTH CENTER NOTES/TREATMENTS: (FOR CAMP USE ONLY)

