

Winter (until May 11)
7460 Market Place Drive
Eden Prairie, MN 55344
Fax 952.922.7149
Voice 952.922.2545
800.242.1909



Summer (after May 11)
PO Box 1308
Lake Hubert, MN 56459
Fax 218.963.2447
Voice 218.963.2339
800.242.1909

(Pages 1-3 To Be Completed by Parent/Guardian)

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Please complete and RETURN TO CAMP BY MAY 1st for all sessions. PLEASE PRINT.
If enrolling after May 1st, please return ASAP.

Camper Name: _____ Session: _____

Age: _____ Birthday (mm/dd/yyyy): _____ Gender: Male Female

*Information must be completed by Parent/Guardian of Minors for all parts of form.

Please do not write "see prior year's information" or "see other forms".

*EMERGENCY ADDRESSES

Parent/Guardian: _____

Home Phone: _____

Home Address: _____ City/State/Zip: _____

Parent 1 Cell: _____ Parent 2 Cell: _____

Business: _____ Business: _____

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

1) Name: _____ 2) Name: _____

Relationship: _____ Relationship: _____

Home: _____ Home: _____

Business: _____ Business: _____

Cell: _____ Cell: _____

*AUTHORIZATION (REQUIRES SIGNATURE):

IMPORTANT – MUST BE COMPLETED FOR ATTENDANCE: 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. A Certificate of Health is required by the State of Minnesota based on a physical examination within 90 days of camp and noting any limitation for participation at camp (see Medical Form).

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: _____

Camper Name: _____

(For Camp Use) Cabin: _____

(For Camp Use) Session: _____

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***Immunization History:**

Provide the month and year for each immunization or attach a copy of your child's clinic/school immunization record. Starred (★) immunizations must be current.

Immunization	Date: Month(s) & Year(s)	Immunization	Date: Month(s) & Year(s)
Tetanus Booster ★ (within 10 years)		Varicella (chicken pox)	
MMR (Measles, Mumps, Rebella) ★		Haemophilus influenzae	
Polio Series ★		Hepatitis B	
Pertussis Booster		Hepatitis A	

If your camper has not been immunized, please complete the Exemption from Immunization Requirements Form available online under Downloads.

***Medication:**

"Medication" is any substance a person takes to maintain and/or improve his or her health and includes vitamins and homeopathic remedies – if required for medical reasons.

- This camper will not take any daily medications while attending Camp Lincoln/Camp Lake Hubert.
- This camper will take the following medication(s) while attending Camp Lincoln/Camp Lake Hubert. Bring enough of each med to last the **ENTIRE** session. Campers takings meds for psychiatric reasons should be on the same medication at the same doses for the three months prior to their arrival.

Note: All medications must arrive in the original, appropriately labeled pharmacy containers (as described in the Parent Handbook).

Name of Medication	Reasons for Taking It	Dose Given & When	Date Started?
		<input type="checkbox"/> Breakfast Dose: _____ <input type="checkbox"/> Lunch Dose: _____ <input type="checkbox"/> Evening Dose: _____ <input type="checkbox"/> Bedtime Dose: _____	
		<input type="checkbox"/> Breakfast Dose: _____ <input type="checkbox"/> Lunch Dose: _____ <input type="checkbox"/> Evening Dose: _____ <input type="checkbox"/> Bedtime Dose: _____	
		<input type="checkbox"/> Breakfast Dose: _____ <input type="checkbox"/> Lunch Dose: _____ <input type="checkbox"/> Evening Dose: _____ <input type="checkbox"/> Bedtime Dose: _____	

The following generic medications are stocked in the camp health center and are used to manage illness and injury as directed by our medical protocols. **Cross out those your camper should NOT be given.**

Acetaminophen (Tylenol)	Diphenhydramine (Benadryl)	Ivy Dry	Triple antibiotic cream
Calamine Lotion	Guaifenesin DM (cough syrup)	Naproxen (Aleve)	Pseudoephedrine (Sudafed)
Ibuprofen (Advil, Motrin)	Chlorpheniramine Maleate (allergy medication)	Tolnaftate (Tinactin)	Lice shampoo/cream (Nix, Elimite)
Bismuth Tabs (Pepto-Bismal)	Generic cough drops	Silver sulfadiazine	Loratadine (Claritin)

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.

***Medical Insurance Information (PLEASE PRINT):**

Please **include** a copy of an insurance card. Copy both sides so addresses and telephone numbers are readable.

Insurance Company: _____

Claims Address: _____

Policy number for your child: _____

If applicable, RxBIN: _____ RxPCN: _____

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

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**** Asthma, Diabetes or Anaphylaxis?**
 Complete an additional form available online at www.lincoln-lakehubert.com or by calling 1-800-242-1909.

GENERAL HEALTH HISTORY: Check “Yes” or “No” for each statement. Explain “Yes” answers below.

- | | YES | NO | | YES | NO |
|--------------------------|--------------------------|---|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Operations or serious injuries (list dates & condition below) | <input type="checkbox"/> | <input type="checkbox"/> | Allergies to foods (explain below) ** |
| <input type="checkbox"/> | <input type="checkbox"/> | Disability or other special needs | <input type="checkbox"/> | <input type="checkbox"/> | Allergies to any medications (explain below) ** |
| <input type="checkbox"/> | <input type="checkbox"/> | (Girls) ever menstruated | <input type="checkbox"/> | <input type="checkbox"/> | Any other allergies (explain below) ** |
| <input type="checkbox"/> | <input type="checkbox"/> | (Girls) if not, has she been told about it | <input type="checkbox"/> | <input type="checkbox"/> | Any chronic recurring conditions (i.e. seizures, ear infections, etc.) |
| <input type="checkbox"/> | <input type="checkbox"/> | Special Equipment (e.g. ear plugs, braces, retainers) | <input type="checkbox"/> | <input type="checkbox"/> | Allergies to foods (explain below) ** |
| <input type="checkbox"/> | <input type="checkbox"/> | Any special dietary needs (list below) | <input type="checkbox"/> | <input type="checkbox"/> | Asthma ** |
| <input type="checkbox"/> | <input type="checkbox"/> | Vegetarian (eats no meat) | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes ** |
| <input type="checkbox"/> | <input type="checkbox"/> | Piercings/tattoos (list below) | <input type="checkbox"/> | <input type="checkbox"/> | Frequent headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Wear glasses, contacts, or protective eyewear | <input type="checkbox"/> | <input type="checkbox"/> | Problems with bed-wetting |
| <input type="checkbox"/> | <input type="checkbox"/> | Have any skin problems | <input type="checkbox"/> | <input type="checkbox"/> | Problems with sleepwalking |
| <input type="checkbox"/> | <input type="checkbox"/> | Traveled outside the country in the past 9 months | <input type="checkbox"/> | <input type="checkbox"/> | Problems with diarrhea/constipation |
| <input type="checkbox"/> | <input type="checkbox"/> | Any conditions or restrictions that affect participation in the program (explain below) | | | |

Please explain “Yes” answers in the space below or on a separate sheet. For travel outside the country, please list name of countries visited and dates.

HEALTH-CARE PROVIDERS:

Name of camper’s primary doctor(s): _____ Phone: _____

Name of dentist(s): _____ Phone: _____

Name of orthodontist(s) _____ Phone: _____

MENTAL, EMOTIONAL AND SOCIAL HEALTH: Check “Yes” or “No” for each statement.

1. This camper has been diagnosed with Attention Deficit Disorder (ADD) or AD/HD Yes No
2. This camper has a psychiatric diagnosis such as depression, OCD, panic/anxiety disorder, eating disorder..... Yes No
3. This camper has an emotional health concern (specify _____) Yes No
4. During the past academic year, this camper has seen or is currently seeing a professional to address mental/emotional concerns Yes No

If “yes,” was the answer to any of the four statements above, attach a statement from your camper’s professional (e.g., psychiatrist, physician) that addresses the following three things:

- (a) Describes the concern and the camper’s management plan (including medication) while in our program;
- (b) Describes the behaviors that will indicate to our staff the your camper’s needs professional referral; and
- (c) Provides recommendation for the camper’s participation in our program.

5. This camper has had a significant life event that continues to affect the camper’s life..... Yes No

If “yes,” please attach written information about the event – death of a loved one, family change, adoption, new sibling, survived a disaster—its impact upon your camper’s life, and care tips for the cabin staff. Keep in mind our staff are generally college students.

WHAT HAVE WE FORGOTTEN TO ASK? Please provide in the space below any additional information about the camper’s health that you think important or that may affect the camper’s ability to fully participate in the camp program. Attach additional information if needed.

