

# HUNGRY MOTHER LUTHERAN RETREAT CENTER CAMPER HEALTH FORM

PLEASE COMPLETE THE ENTIRE FORM AND BRING WITH YOU ON THE DAY OF REGISTRATION.

Each camper **MUST HAVE** a completed **AND SIGNED** health form or will not be allowed to participate in the program.

Name \_\_\_\_\_  
Last First MI Name Used  
Birth Date \_\_\_\_\_ Age \_\_\_\_\_  Male  Female  
Parent/Guardian Name(s) \_\_\_\_\_ Relationship \_\_\_\_\_  
Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Email \_\_\_\_\_

**Name of Person to call if camper has problems while at camp** \_\_\_\_\_  
Day Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**IF THE ABOVE ARE NOT AVAILABLE IN AN EMERGENCY, PLEASE NOTIFY:**

**Emergency Contact #1** \_\_\_\_\_ Relationship \_\_\_\_\_  
Day Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Emergency Contact #2** \_\_\_\_\_ Relationship \_\_\_\_\_  
Day Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Physician name** \_\_\_\_\_ Phone \_\_\_\_\_

**Dentist name** \_\_\_\_\_ Phone \_\_\_\_\_

### Health Insurance Information

HMLRC does not provide camper sickness insurance but does have secondary accident insurance. The parent/legal guardian is responsible for all charges associated with an accident or illness.

Carrier Name \_\_\_\_\_

Carrier Address \_\_\_\_\_

Policy # \_\_\_\_\_ Phone \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_

Policy Holder's Social Security # \_\_\_\_\_ Policy Holder's Date of Birth \_\_\_\_\_

If you have an Rx card, Bin # \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_

### MEDICAL RELEASE AND AUTHORIZATION FOR TREATMENT

The undersigned, as parent/legal guardian of the camper, authorizes Hungry Mother Lutheran Retreat Center (HMLRC) delegated leaders, directors and medical personnel they have selected to consent to any medical/hospital care deemed necessary. I consent to the release of this health history and examination form to the emergency room, hospital, or doctor's office providing care. HMLRC will endeavor, but is not required, to communicate with me prior to treatment. The undersigned releases HMLRC and its designated leaders and directors from any liability and claims arising from any consent given in good faith in connections with diagnosis or treatment. The undersigned certifies that he/she has full authority to sign this Release and Authorization. This completed form may be photocopied for off-site activities.

**Printed Name** \_\_\_\_\_ **Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**IF THE PARTICIPANT IS UNDER 18 YEARS OF AGE A PARENT/GUARDIAN MUST SIGN THE MEDICAL RELEASE AND AUTHORIZATION! A SIGNED RELEASE IS A PREREQUISITE TO PARTICIPATE IN CAMP!!**

CAMPER NAME: \_\_\_\_\_

**PAST MEDICAL TREATMENT & HEALTH HISTORY:**

| <b>Has/does the participant:</b>                         | <b>Yes</b>               | <b>No</b>                | <b>Yes</b>   | <b>No</b>   |
|--|--------------------------|--------------------------|--|---|
| Had any recent injury, illness or infectious disease.... | <input type="checkbox"/> | <input type="checkbox"/> | Ever had high blood pressure .....                     | <input type="checkbox"/> <input type="checkbox"/> |
| Have a chronic or recurring illness/condition .....      | <input type="checkbox"/> | <input type="checkbox"/> | Ever had back problems .....                           | <input type="checkbox"/> <input type="checkbox"/> |
| Have frequent headaches .....                            | <input type="checkbox"/> | <input type="checkbox"/> | Ever had problems with joints (e.g.,knees,ankles) .... | <input type="checkbox"/> <input type="checkbox"/> |
| Ever had a head injury .....                             | <input type="checkbox"/> | <input type="checkbox"/> | Have any skin problems .....                           | <input type="checkbox"/> <input type="checkbox"/> |
| Have frequent ear infections .....                       | <input type="checkbox"/> | <input type="checkbox"/> | Had mononucleosis in the past 12 months .....          | <input type="checkbox"/> <input type="checkbox"/> |
| Ever passed out during or after exercise .....           | <input type="checkbox"/> | <input type="checkbox"/> | Have problems with sleepwalking .....                  | <input type="checkbox"/> <input type="checkbox"/> |
| Ever had chest pain during or after exercise .....       | <input type="checkbox"/> | <input type="checkbox"/> | Have a history of bed-wetting .....                    | <input type="checkbox"/> <input type="checkbox"/> |
| Ever had seizures .....                                  | <input type="checkbox"/> | <input type="checkbox"/> | Ever had an eating disorder .....                      | <input type="checkbox"/> <input type="checkbox"/> |
| Ever had an operation .....                              | <input type="checkbox"/> | <input type="checkbox"/> | Been diagnosed as ADD or ADHD .....                    | <input type="checkbox"/> <input type="checkbox"/> |

Please explain any "yes" responses \_\_\_\_\_  
\_\_\_\_\_

**Allergies:**  Hay Fever  Poison Ivy  Insect Stings  Food \_\_\_\_\_  Other \_\_\_\_\_

**Asthma:**  Severe  Moderate  Mild Triggers? \_\_\_\_\_

**Nutritional/dietary restrictions:** \_\_\_\_\_  
Diabetic?  Yes  No Vegetarian?  Yes  No

Has the camper had any of the following:  Measles  Chicken Pox  Mumps  German Measles

Please indicate the date (MM/YY) of the last immunizations/booster for:

DTP \_\_\_\_\_ MMR \_\_\_\_\_ TD (Tetanus) \_\_\_\_\_ Hepatitis B \_\_\_\_\_ HIB \_\_\_\_\_

Does the camper know how to swim?  Yes  No  Somewhat

Special instructions regarding swimming/water: \_\_\_\_\_

Is camper currently taking any prescribed or over-the-counter medicine?  Yes  No

If "yes", what medications? \_\_\_\_\_

Which of these medications will the camper be bringing to camp? \_\_\_\_\_

**ANY MEDICATIONS TO BE TAKEN AT CAMP MUST BE IN ORIGINAL CONTAINERS WITH ORIGINAL LABELS INTACT.**

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**PHYSICIAN'S EXAM:**

**Physician must either complete this section of the health form or a copy of assigned, completed physical from the last 24 months must be attached to this form.**

**Date of last exam** (must be within past 24 months of camp week) \_\_\_\_\_

Any physical condition requiring restriction(s) on participation in the camp program and a **description of that restriction** (please describe in detail – attach further documentation if needed) \_\_\_\_\_

Any current or on-going treatment or medications to be administered at camp (name, dosage, frequency) \_\_\_\_\_

Any modified nutritional/meal plan: \_\_\_\_\_

Any activities to be limited: \_\_\_\_\_

In my opinion, the applicant's condition (circle one) **does/does not** preclude participation in a camp program.

In my opinion, the applicant's condition (circle one) **does/does not** preclude participation in a camp program of high activity including mountain trail hiking and biking.

**Licensed physician's signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Phone \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**CAMPER INFORMATION SHEET**      **Name:** \_\_\_\_\_

We want to provide your camper with the best possible camp experience and are interested in the spiritual, physical and social growth of each individual. The following information will help our staff and counselors meet these needs in the best way possible. Please be specific.

- This camper is attending an overnight camp for the first time?
- This camper has attended another overnight camp, but this is the first time at HMLRC.
- This camper has attended an HMLRC camp before. # of years \_\_\_\_\_

Please describe the camper's feelings about attending camp. \_\_\_\_\_

Who made the decision that the camper would attend camp? \_\_\_\_\_

Are there any major events or significant situations of which we should be aware? \_\_\_\_\_

Has the camper had any negative camp (or other) experiences of which we should be aware? \_\_\_\_\_

What fears does the camper have, if any? \_\_\_\_\_

What concerns do you have about the camper spending a week at camp? \_\_\_\_\_

What camp activities do you think the camper will enjoy the most? \_\_\_\_\_

Please anticipate any situations, times of day or activities that might be difficult for your camper. List these and give our staff advice about the best way to help the camper and manage behavior in a positive way:

Please give us any additional information that will help us give your camper the best experience possible:

**Thanks for the information. Please know it will only be seen by staff working directly with your camper.**