Camp Omega Health Information Form

Camp Session Name & Date ______________________

Name ______________________ Birthdate __________ Sex ________ Age __________

Parent or Guardian (or Spouse): ______________________

Home Address ______________________ City __________ State ______ Zip ______ Phone __________

Business Address ______________________ City __________ State ______ Zip ______ Phone __________

Emergency Contact: ______________________

Home Address ______________________ City __________ State ______ Zip ______ Phone __________

Family Physician: ______________ Phone __________ **Dentist:** ______________ Phone __________

Medical Insurance: ______________ Address: __________ **Insured Name**: ______________

Medications Being Taken: List all meds. (including over-the counter) taken routinely. Bring enough in original packaging with complete instructions for entire camp period.

Med. #1 __________ Dosage ______ Times taken each day ___ **Med. #2** __________ Dosage ______ Times taken each day ___

Allergies Please list all medication, food and other allergies. If you need additional room please attach.

Allergy: ______________ Reaction and management: ______________________

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Restrictions: Does not eat: ❑ Red Meat ❑ Pork ❑ Dairy Products ❑ Poultry ❑ Eggs ❑ Other ______________

Explain any activity restrictions or limitations: ______________________

Information about participant's behavior, physical, emotional, or mental health about which the camp should be aware:

______________________ (attach additional info. if needed)

Immunization History Please record the immunization date

Vaccine	date	date	date	date	date	date
DPT						
TD (tetanus/diptheria)						
Polio						
MMR						
Or Measles						
Or Mumps						
Or Rubella						
Haemophilus influenza B						
Hepatitis B						
Varicella (chicken pox)						

General Questions (explain "yes" below)	Yes	No
1. Recent injury or illness?	❑	❑
2. Chronic or recurring illness/condition?	❑	❑
3. Ever had seizures	❑	❑
4. Ever had chest pain during or after exercise?	❑	❑
5. Have diabetes?	❑	❑
6. Have asthma?	❑	❑
7. If female, have an abnormal menstrual history?	❑	❑
8. Have a history of bed-wetting?	❑	❑
9. Ever had frequent ear infections?	❑	❑
10. Had mononucleosis in the past 12 months?	❑	❑
11. Ever had back problems?	❑	❑
12. Have frequent headaches?	❑	❑
13. Ever had high blood pressure?	❑	❑

Please explain any "yes" answers: ______________________

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Important - This box must be completed for attendance

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 medical personnel selected by the camp director to provide routine health care; to administer medications; order x-rays, routine tests, treatment, to release any records necessary for insurance purposes; and to provide or arrange necessary related 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 the person named above. The completed forms may be photocopied for trips off camp.

Photo Image Release: As a participant in a Camp Omega event, I give permission and consent to allow photos, videos, and interviews to be taken of the above mentioned individual during the camp session. I further give consent that any such images or interviews may be published and used to illustrate and promote Camp Omega and the National Lutheran Outdoors Ministry.

★ **Signature** of parent or guardian or adult guest/staff ______________________ **Date** __________

For Camp Use **- In-Camp Health Screening Record** Date of screening ______________ Time ______ Conducted by __________

Meds Received at Screening ______________________

Updates / Additions to health history noted [ ] Yes [ ] No [ ] None Required

Current Health Needs Identified: ______________________

Observational Notes ______________________

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