

Camp Omega Health Information Form

Camp Session Name & Date _____

Last Name _____ First Name _____ Gender M F Birthdate _____ Age _____

Name of Parent(s)/Guardian(s) (or Spouse) _____

Home Address _____ City _____ State _____ Zip _____

Phone Numbers: Home _____ Mobile _____ Work _____ Email: _____

Emergency Contact (other than parent/guardian) _____ Relationship _____

Phone Numbers: Home _____ Mobile _____ Work _____

Medical Insurance Co. _____ Policy/Certificate Number _____

Policy Holder's Name _____

Physician _____ Phone _____ Dentist _____ Phone _____

Medications Being Taken: List all medications (including over-the counter) taken routinely. Bring enough in original packaging with complete instructions for entire camp period. Medications will be dispensed according to label instructions.

Medication #1 _____ Dosage _____ When taken each day _____

Medication #2 _____ Dosage _____ When taken each day _____

Medication #3 _____ Dosage _____ When taken each day _____

Are all immunizations require for school up to date? Yes or No Month & Year of Last Tetanus Shot _____ / _____

Health Information

General Questions (if "yes" explain below)	Yes	No
1. Has food allergies?	<input type="checkbox"/>	<input type="checkbox"/>
2. Must have a gluten free diet?	<input type="checkbox"/>	<input type="checkbox"/>
3. Must have a dairy free diet?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has environmental allergies?	<input type="checkbox"/>	<input type="checkbox"/>
5. Has a heart condition?	<input type="checkbox"/>	<input type="checkbox"/>
6. Is subject to fainting?	<input type="checkbox"/>	<input type="checkbox"/>
7. Is subject to upset stomach?	<input type="checkbox"/>	<input type="checkbox"/>
8. Is subject to motion sickness?	<input type="checkbox"/>	<input type="checkbox"/>
9. Has a reaction to bee sting?	<input type="checkbox"/>	<input type="checkbox"/>
10. Has a reaction to penicillin?	<input type="checkbox"/>	<input type="checkbox"/>
11. Has a reaction to poison ivy, oak or sumac?	<input type="checkbox"/>	<input type="checkbox"/>
12. Has a reaction to other drugs?	<input type="checkbox"/>	<input type="checkbox"/>
13. Has had a recent injury or illness?	<input type="checkbox"/>	<input type="checkbox"/>

General Questions continued...	Yes	No
14. Has a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>
15. Has ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
16. Has had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
17. Has diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
18. Has asthma?	<input type="checkbox"/>	<input type="checkbox"/>
19. If female, has an abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
20. Has a history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
21. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>
22. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
23. Has had back problems?	<input type="checkbox"/>	<input type="checkbox"/>
24. Has frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
25. Has had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
26. Has activity restrictions or limitations?	<input type="checkbox"/>	<input type="checkbox"/>

Please Attach a Copy of the Participants Immunization Records.

Explanations of activity restrictions or limitations if any: _____

Explanations of past medical treatment if any: _____

Explanation of any physical, mental, or psychological conditions requiring medication, treatment or restrictions if any: _____

Important - This Form Must Be Signed Prior To Participation!

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 authorize the Camp Omega staff to administer medications and first aid as deemed necessary well as authorize the medical personnel selected by the camp staff to provide routine health care and emergency medical care by medical staff to hospitalize, secure treatment for, order injection, anesthesia, blood transfusions, or surgery, and to release any records necessary for insurance purposes as well as provide or arrange necessary related transportation for the above named participant. This form may be photocopied.

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 in a variety of ways and used to illustrate and promote Camp Omega and the National Lutheran Outdoors Ministry Association.

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

For Camp Use -

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

Notes: _____

Release and Application for Exemption from Physical Examination and Immunization Requirements

It is respectfully requested that my child be exempted from the physical examination and all immunization requirements required for attendance at Camp Omega. To the best of my knowledge and belief, s/he is and has been in normal good health and is free from all communicable or contagious diseases.

Should my child manifest any condition where there appears to be reasonable grounds for suspecting the presence of a communicable or contagious diseases, I agree that a physical examination may be performed. Also, I agree that if any such disease is found, he/she will comply with the regular quarantine or isolation procedures of the camp and of the community.

It is further understood that, should an emergency arise, I will be notified immediately. However, in the event that we cannot be located immediately, the authorities of the camp may take such temporary measures as they deem necessary.

I release and forever discharge the camp and each and every one of its officers, directors, partners, shareholders, employees, agents, insurers, affiliates, successors in interest, attorneys, or any other person or persons associated with any or all of them or any variation in the name of any or all of them who might be liable (the "Released Parties") from all causes of action, suits, claims, demands, or any other damages or costs associated with actions taken by the Released Parties relative to the health, sickness, and treatment of my child

I further understand and acknowledge that I make this release in full accord and satisfaction of and in compromise of any current or future disputed or alleged claims or causes of action relative to the health, sickness, and treatment of my child against the Released Parties.

I represent and acknowledge that I have read and understand this agreement and release and warrant that all statements made herein are true to the best of my knowledge. I further warrant and acknowledge that I am of legal age, legally competent to execute this agreement and release, and accept full responsibility there for.

First & Last Name of Child

Date

Signature

Printed Name

Address City State Zip

Contact Phone