



Health History Form for Children, Youth and Adults Attending Camps at Lutherans Outdoors in South Dakota

NeSoDak, Klein Ranch, Outlaw Ranch and Atlantic Mountain Ranch

(To be filled in by parents/guardian of minors or by adult campers/staff members themselves.)

Camper Name _____ Birthdate _____ Sex _____ Age _____

Parent/Guardian (or Spouse) _____

Home Address _____
Street City State Zip

Day Phone (_____) _____ Night (_____) _____ Cell (_____) _____

Second Parent/Guardian or Emergency Contact _____

Home Address _____
Street City State Zip

Day Phone (_____) _____ Night Phone (_____) _____ Cell (_____) _____

Camper Name: _____

Health History
 (Check / Give approximate dates)

_____ Frequent Ear Infections
 _____ Heart Defect/Disease
 _____ Convulsions
 _____ Diabetes
 _____ Bleeding/Clotting Disorder
 _____ Hypertension
 _____ Mononucleosis
 _____ Psychiatric Treatment

Diseases

_____ Chicken Pox
 _____ Measles
 _____ German Measles
 _____ Mumps

Allergies (Dates not Needed)

_____ Hay Fever
 _____ Ivy Poisoning, etc.
 _____ Insect Stings
 _____ Penicillin
 _____ Other Drugs
 _____ Asthma
 _____ Other (Specify) _____

(Attach paper if more space needed for explanations)

Has this camper ever required any psychiatric counseling or hospitalization? Yes No
 If Yes, Explain _____

Current treatment & medications _____

Current behavioral plan _____

Past history of treatment, medications and behavioral plans _____

Operations or serious injuries (dates) _____

Disability or chronic or recurring illness _____

Current medications *(Please send prescriptions in original bottles with directions on the label)* _____

Name of dentist/orthodontist _____ Phone _____

Name of family physician _____ Phone _____

Date of last physical examination _____

Do you carry family medical / hospital insurance? Yes No
 If so, indicate:

Carrier _____	Policy Holder: _____
<small>Complete Address of Insurance Carrier:</small>	Policy/Group # _____
Street _____	Certificate # _____
City _____ State _____ Zip _____	

ATTACH COPY OF YOUR INSURANCE CARD, PLEASE!

IMPORTANT - THIS BOX MUST BE COMPLETED AND SIGNED FOR ATTENDANCE:

Warning, under South Dakota Law, an equine professional is not liable for any injury or death of a participant in equine activities resulting from the inherent risks of equine activities, pursuant to SD 42-11-2.

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 camp health care personnel to provide routine health care and to administer medications brought to camp; and to the medical personnel selected by the camp director to order X-rays, routine tests, treatment, and necessary 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 my child as named above. The completed forms may be photocopied for trips out of camp. **Give permission for my or my child's photo to be used for publicity purposes.**

Signature of parent/guardian or adult camper _____ Date _____

I also understand and agree to abide with the restrictions placed on my camp activities:

Signature of minor _____ Date _____

Please complete other side also.

Immunization History

Please record the date (month and year) of basic immunizations and most recent booster doses.

** IMPORTANT to indicate tetanus shot date.

Vaccines	Date of Basic Immunization	Date of Last Booster
Tetanus **important**		
DTAP (series of 5) (Diphtheria, Tetanus, and Pertussis)		
TDAP (youth over 10)		
MMR (series of 2) (Measles, Mumps, Rubella)		
Varicella (series of 2)		
Polio (series of 4)		
Hepatitis B (series of 3)		
Others		

Recommendations and Restrictions While at Camp

Current medications (prescribed & over-the-counter) _____

Activities to be restricted due to health reasons _____

Description of any current physical conditions requiring medication, treatment, special considerations, restrictions while at camp. _____

Description of any current mental or psychological conditions requiring medication, treatment, special restrictions or considerations while at camp _____

Any medication prescribed or over the counter to be administered at camp (specific dosages) _____

Medications need to be turned into the camp health care personnel upon arrival. **Please send prescriptions in the original bottle with the doctors directions on the label.**

Any over-the-counter medications **NOT** to be given to camper while at camp _____

Any medically prescribed meal plan or dietary restrictions _____

Any allergies (food, drugs, plants, insects, etc.) _____

The camper is under the care of a physician for the following condition(s): _____

Any time health care outside the camp community is needed, parents/guardian will be notified. If you wish to be notified in any other circumstances, please list here _____

For Females Only:

Has this person menstruated? _____ If not, has she been told about it? _____

If so, is her menstrual history normal? _____

Special Considerations for health care person to be aware of: _____

**BRING THIS HEALTH FORM WITH YOU TO CAMP
YOU WILL NOT BE PERMITTED TO REGISTER WITHOUT YOUR HEALTH FORM!!**



Lutherans Outdoors in South Dakota