2027 LUTHER CREST BIBLE CAMP
HEALTH FORM AND PERMISSION TO PARTICIPATE

Name: _____
Date of Birth: _____
Session: _____

A complete health history IS necessary, and campers MUST have a signed and completed health form to attend camp. A physical is required ONLY if there are any health problems, activity limitations, or if the camper is under doctor's care while attending camp. If the camper is required to have a physical for camp attendance, and has had one within the last 12 months, then a photocopy of the signed physical may be attached to this form.

Name: _____
Date of Birth: _____ ☐ Male ☐ Female
Address: _____
City: _____ Grade (2026-27) _____
State/Province: _____ Zip/Postal Code: _____

We will call you in case of an emergency requiring professional medical treatment or if we have questions about your child. Please provide contact information for others who know your child and with whom we may consult if you are not available. We will assume you have spoken with these individuals and they are willing to assist if needed.

PARENT/GUARDIAN #1

Name: _____ Relationship: _____
Email: _____
Phone #1: _____
Phone #2: _____
Address: _____
City: _____
State/Province: _____ Zip/Postal Code: _____

PARENT/GUARDIAN #2

Name: _____ Relationship: _____
Email: _____
Phone #1: _____
Phone #2: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____
Phone #1: _____
Phone #2: _____

Health Care Providers

Primary: _____ Phone: _____
Dentist: _____ Phone: _____
Orthodontist: _____ Phone: _____

Insurance Information

In the event of an accident/injury requiring medical attention, personal insurance will be considered the primary carrier. Camper medical and accident coverage must be provided by a parent or guardian. If medical care is necessary, please send bill to:

☐ Parents/Guardians ☐ Health insurance company listed below

Insurance Company: _____
Address: _____
City: _____
State: _____ Zip Code: _____
Policy Number: _____ Group/ID: _____
Name of Policy Holder: _____

Diet / Nutrition

☐ Regular ☐ Vegetarian ☐ Vegan ☐ Lactose Intolerant ☐ Other: _____

Restrictions

This camper is free from illness, injury, or surgery which would affect participation ☐ Yes ☐ No

General Health History

Check "Yes" or "No" for each statement. Explain "Yes" answers below.

1. Mononucleosis? ☐ Yes ☐ No
2. Chicken pox? ☐ Yes ☐ No
3. Measles? ☐ Yes ☐ No
4. Mumps? ☐ Yes ☐ No
5. German measles? ☐ Yes ☐ No
6. Abnormal hearing? ☐ Yes ☐ No
7. Abnormal vision? ☐ Yes ☐ No
8. Asthma? ☐ Yes ☐ No
9. Diabetes? ☐ Yes ☐ No
10. Heart defect/disease? ☐ Yes ☐ No
11. Seizure disorder? ☐ Yes ☐ No
14. Headaches? ☐ Yes ☐ No
13. Sleepwalking? ☐ Yes ☐ No
14. Hypertension? ☐ Yes ☐ No
15. Bleeding/clotting disorder? ☐ Yes ☐ No
16. Bedwetting? ☐ Yes ☐ No
17. Frequent ear infections? ☐ Yes ☐ No
19. Frequent colds? ☐ Yes ☐ No
20. Frequent nighttime bathroom use? ☐ Yes ☐ No
21. Makes noise when sleeping? ☐ Yes ☐ No
22. For females, been told about menstruation? ☐ Yes ☐ No
23. For females, has menstrual cramps? ☐ Yes ☐ No
24. For females, has a regular periods? ☐ Yes ☐ No

Mental, Emotional, And Social Health

Check "Yes" or "No" for each statement. Explain "Yes" answers below.

1. Emotional health concerns? ☐ Yes ☐ No
2. Learning disability? ☐ Yes ☐ No
3. Diagnosed with Attention Deficit Disorder (ADD or ADHD)? ☐ Yes ☐ No
4. Diagnosed with depression, panic or anxiety disorder, OCD? ☐ Yes ☐ No
5. Under professional care for emotional/mental concerns? ☐ Yes ☐ No

2027 LUTHER CREST BIBLE CAMP
HEALTH FORM AND PERMISSION TO PARTICIPATE

Name: _____
Date of Birth: _____
Session: _____

Immunization History Provide the month and year for each immunization.

	Dose 1 (Month/Year)	Dose 2 (Month/Year)	Dose 3 (Month/Year)	Dose 4 (Month/Year)	Dose 5 (Month/Year)
Diphtheria, tetanus, pertussis (DTaP or TdaP)					
Mumps, measles, rubella (MMR)					
Polio (IPV)					
Haemophilus influenzae type B (HIB)					
Pneumococcal (PCV)					
Hepatitis B					
Hepatitis A					
Varicella (Chicken Pox)			☐ Had Chicken Pox? Date:		
Meningococcal meningitis (MCV4)					

TB Test Date: _____
☐ Negative ☐ Positive

Tetanus (dT or TdaP) Date: _____

Influenza
Seasonal Date: _____
H1N1 Date: _____

If camper is **NOT** fully immunized, please sign the following statement: I understand and accept the risks to my child from **NOT** being fully immunized.

Printed Name _____ Relationship to Camper _____ Signature _____ Date _____

Medications ☐ No Medications

All medications MUST be in the original pharmacy containers and labeled appropriately. Campers MUST turn in all medications, vitamins and over-the-counter drugs to the Health Care Person upon arrival. For the safety of your child and other campers self-medicating is not allowed.

_____
_____
_____
_____
_____

Allergies List all allergies and reactions ☐ No Known Allergies ☐ Drug ☐ Food ☐ Environmental

_____
_____
_____

What Have We Forgotten to Ask?

Please provide in the space below any additional information about the individual's health that you think important or that may affect the individual's ability to fully participate in the camp program.

_____
_____
_____
_____
_____

Parent/Guardian Authorization for Health Care *(Adults participating in a program will sign on their own behalf.)*

The privacy of you, of your family and of your child is very important to us. This Health Form and the information contained herein are only shared with a camper's Counselor, the Health Care Manager, the Camp Directors, and Hospital/Clinic Staff if required. This form will be securely stored in Luther Crest's records for 20 years - at which time it will be destroyed.

My child and/or my family have permission to participate in all aspects of the program of Luther Crest Bible Camp and I agree that the camp or its personnel will not be held responsible for accidents arising from participation. I also give permission for any pictures or video taken of me, our family and of my child to be used for promotional purposes.

This Health Form is complete and correct, and the person or persons described have permission to engage in all camp activities except as noted by me and/or the examining physician. I give permission to the camp to: 1) provide ongoing health care, and 2) select medical personnel and to order X-rays or routine tests or treatment for the camper listed above. In the event that I cannot be reached in an EMERGENCY, I give permission to the physician selected by the Camp Director to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for my child named above. I understand that information about my child's health will be shared with the appropriate counseling, food service, or other Luther Crest staff. This form may be photocopied for use out of camp.

Name _____ Relationship to Camper _____ Signature _____ Date _____