

FLATHEAD LUTHERAN BIBLE CAMP HEALTH HISTORY FORM

Dates of Camp Attendance _____ Program Attending _____

Please mail this form to the Camp: 603 Main St., Kalispell, MT 59901 by June 15. (Notify FLBC in writing of any changes in information between the time this form is completed and the dates of camp attendance.)

Name _____ DOB _____ Age at Camp _____ Sex _____
Last First Initial Date of Birth

Home Address/City/State/Zip _____

Home Phone _____ Social Security # of participant _____

Height _____ Weight _____ If female, has she menstruated? _____

Custodial Parent/Guardian _____ Phone _____

Address (if different than above) _____

Work Phone _____ Cell Phone _____ Email _____

Second Emergency Contact _____ Relationship _____

Address _____

Home Phone _____ Work Phone _____ Cell _____

Insurance Information: (Photocopy the front and back of insurance card and attach to this form.)

Is the participant covered by family medical/hospital insurance? ___ yes ___ no

If so, indicate the carrier or plan name _____ Group # _____

Primary Physician's Name _____ Phone _____

Address _____

Dentist/Orthodontist Name _____ Phone _____

Address _____

This health history is correct and complete as far as I know. The person herein named has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for me/my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. It is my intention that the camp be treated as acting *in loco parentis* if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the purpose of disclosing protected health information pursuant to the privacy regulations promulgated pursuant of the Health Insurance Portability and Accountability Act of 1996. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent or guardian of camper or staff _____

Print Name _____ Date _____

Immunizations: Please provide the date of last immunization for each.

DPT _____ TD (Tetanus/Diphtheria) _____ MMR _____ Polio _____

Hepatitis B _____ Haemophilus influenza B _____ Varicella (chicken pox) _____

Explain any restrictions to activity: (what cannot be done, limitations, or adaptations that are necessary)

Which of the following has the participant had?

- Measles German measles Hepatitis A Hepatitis C
 Chicken Pox Mumps Hepatitis B
 TB Mantoux Test: Date of last test _____ Result: Positive Negative

Allergies: List all known

Describe reaction and management of reaction

Medical Allergies

1. _____
2. _____
3. _____

- _____

Food Allergies

1. _____
2. _____
3. _____

- _____

Other Allergies

1. _____
2. _____
3. _____

- _____

Medications Being Taken (Please list ALL medications, including over-the-counter or nonprescription drugs, taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician, the name of medication, the dosage, and the frequency of administration.)

This person takes NO medications on a routine basis.

This person takes the medications as follows:

Med #1 _____ Dosage _____ Times taken each day _____

Reason for taking _____

Med #2 _____ Dosage _____ Times taken each day _____

Reason for taking _____

Med #3 _____ Dosage _____ Times taken each day _____

Reason for taking _____

List any medications taken during the school year that participant does/may not take during their time at camp:

General Questions: (explain "yes" answers below)

Has/does the participant:

- | | | | |
|---|--|---|--|
| 1. Had any recent injury/illness/or infectious disease? | <input type="checkbox"/> yes <input type="checkbox"/> no | 13. Have a chronic or recurring illness/condition? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 2. Ever been hospitalized? | <input type="checkbox"/> yes <input type="checkbox"/> no | 14. Ever had surgery? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 3. Have frequent headaches? | <input type="checkbox"/> yes <input type="checkbox"/> no | 15. Ever had a head injury? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 4. Wear glasses, contacts or protective eye wear? | <input type="checkbox"/> yes <input type="checkbox"/> no | 16. Ever had frequent ear infections? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 5. Ever passed out during exercise? | <input type="checkbox"/> yes <input type="checkbox"/> no | 17. Ever had seizures? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 6. Ever had chest pain during exercise? | <input type="checkbox"/> yes <input type="checkbox"/> no | 18. Ever had high blood pressure? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 7. Ever been diagnosed with a heart murmur? | <input type="checkbox"/> yes <input type="checkbox"/> no | 19. Ever had back problems? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 8. Ever had problems with joints (knees, ankles)? | <input type="checkbox"/> yes <input type="checkbox"/> no | 20. Have diabetes? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 9. Have asthma? | <input type="checkbox"/> yes <input type="checkbox"/> no | 21. Had mononucleosis in the past year? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 10. Had problems with diarrhea/constipation? | <input type="checkbox"/> yes <input type="checkbox"/> no | 22. Have problems with sleepwalking? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 11. If female, have an abnormal menstrual history? | <input type="checkbox"/> yes <input type="checkbox"/> no | 23. Have a history of bed-wetting? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 12. Ever had an eating disorder? | <input type="checkbox"/> yes <input type="checkbox"/> no | 24. Ever had emotional difficulties for which professional help was sought? | <input type="checkbox"/> yes <input type="checkbox"/> no |

Please explain any "yes" answers, noting the number of the questions.

Please attach a sheet of paper providing any additional information about the participant's behavior and physical, emotional, or mental health that the camp should be aware.