## LUTHER CREST BIBLE CAMP HEALTH FORM AND PERMISSION TO PARTICIPATE Day Camp 2023

Please complete the following health form. Campers MUST have a signed and completed health form to attend camp.

| Camper Name:                                                                                            |                                                                                                            | First                             |                         | Middle Initial                                                                                                    |
|---------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|-----------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------|
| Mailing Address:                                                                                        |                                                                                                            |                                   |                         | Medic Medi                                                                                                        |
| City, State, ZIP:                                                                                       |                                                                                                            |                                   |                         |                                                                                                                   |
| •                                                                                                       |                                                                                                            |                                   |                         | Completed ('22 - '23 School Year):                                                                                |
| Parent/Guardian:                                                                                        |                                                                                                            |                                   | Day Phone N             | Number:                                                                                                           |
| Relationship:                                                                                           | Evening Phone                                                                                              | Number:                           | Ce                      | ell Phone Number:                                                                                                 |
| considered PRIMARY CA                                                                                   |                                                                                                            |                                   |                         | ical attention, your personal insurance will be                                                                   |
| • •                                                                                                     |                                                                                                            |                                   |                         |                                                                                                                   |
| In the event the<br>(Please Check                                                                       |                                                                                                            |                                   |                         | the bill should be sent directly to:<br>ents' Health Insurance Company                                            |
| Health History: Luther                                                                                  | Crest uses this informati                                                                                  | 2) Educate                        | e counseling staf       | n an informed background about your child; if about their respective camper needs; t dietary needs (onsite only). |
| -                                                                                                       | o known allergies.                                                                                         |                                   |                         | ance(s):                                                                                                          |
|                                                                                                         | llergies this cause anaphy<br>ion(s) and what can be d                                                     |                                   |                         | ional information if needed):                                                                                     |
| General Health History  Mononucleosis  Mumps  This camper has hearing This camper is free from          | □ Chicken Pox<br>□ Hay Fever<br>ng within normal ranges.                                                   |                                   |                         | nas vision within normal range.                                                                                   |
| health care and a supportiv  This camper has r  This camper has t  Asthma Hypertension Other (please de | e environment. to chronic concerns and it the following chronic con to Diabetes to Frequent Colds escribe) | is capable of full partincern(s): | cipation.  ease ections | □ Seizure Disorder □ Bleeding/Clotting Disorder                                                                   |

| Mental/Emotional Health Concerns: Check "Yes" or "                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | No" for each statement                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
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| This camper has an emotional health concern                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| This camper has a learning disability                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| This camper has been diagnosed with Attention Deficit Disord                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| If "yes" was answered to anything in this section, please attac                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ch a statement if any special considerations should be taken                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | l medications MUST be in the original pharmacy containers and labeled                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ns and over-the-counter drugs to the Health Care Person upon arrival. For                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| the safety of your child and other campers self-medicating is a                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | not allowed.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| This camper does not take any medication.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ☐ This camper takes routine medication (complete the following):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| Name of Medication:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Name of Medication:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Reason:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Reason:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| Dose:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Dose:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| Time(s) of Day:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Time(s) of Day:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | •                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Immunization:</b> Please note month and year of the shots or                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | the most recent booster.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| DTP: Diphtheria, Tetanus, Pertussis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Td: Tetanus Booster                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| MMR: Measles, Mumps, Rubella                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Others:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| With Weastes, Wamps, Rubella                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Others.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Doctor/Dentist Contact Information:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Dhono                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| Name of Camper's Physician                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Phone                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
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|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| THIS FORM MUST RE SI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | CNED FOR CAMP ATTENDANCE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
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|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| Parent/Guardian Authorization for Health Care: This Hea                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | lth Form is complete and correct, and the person described has permission                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
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