

CAMP:  NeSoDak  Klein Ranch  Outlaw Ranch  Fort Courage  Servant Camp  AMR Adv  
 Week at Camp \_\_\_\_\_ Year: \_\_\_\_\_ Cabin Group: \_\_\_\_\_

**Bring this form with you to camp!**

## 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

Phone (\_\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_\_) \_\_\_\_\_

**Camper Name:**

<b>Health History</b> (Check / Give approximate dates)	
<input type="checkbox"/> Frequent Ear Infections	
<input type="checkbox"/> Heart Defect/Disease	
<input type="checkbox"/> Convulsions	
<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Bleeding/Clotting Disorder	
<input type="checkbox"/> Hypertension	
<input type="checkbox"/> Mononucleosis	
<input type="checkbox"/> Psychiatric Treatment	
<b>Diseases</b>	
<input type="checkbox"/> Chicken Pox	
<input type="checkbox"/> Measles	
<input type="checkbox"/> German Measles	
<input type="checkbox"/> Mumps	
<b>Allergies</b> (Dates not Needed)	
<input type="checkbox"/> Hay Fever	
<input type="checkbox"/> Ivy Poisoning, etc.	
<input type="checkbox"/> Insect Stings	
<input type="checkbox"/> Penicillin	
<input type="checkbox"/> Other Drugs	
<input type="checkbox"/> Asthma	
<input type="checkbox"/> 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* \_\_\_\_\_

Operations or serious injuries (dates) \_\_\_\_\_

Disability or chronic or recurring illness \_\_\_\_\_

Activities encouraged or limited by physician \_\_\_\_\_

Dietary modifications \_\_\_\_\_

Current medications (send with instructions) \_\_\_\_\_

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 _____ <small>Complete Address of Insurance Carrier:</small> _____ Street _____ City _____ State _____ Zip _____	Policy Holder: _____ Policy/Group # _____ Certificate # _____
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**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
Diphtheria	1	1
Pertussis (Whooping Cough)      DPT	2	2
Tetanus **	3	
<b>OR</b>		
Tetanus **                              TD		
Diphtheria		
<b>OR</b>		
Tetanus **		
Oral Polio (Sabin) TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measles, Rubeola)		
Mumps		
Rubella (German measles, 3-day measles)		
Tuberculin test given _____ (most recent)		
Other		

**Recommendations and Restrictions While at Camp**

Any treatment to be continued at camp \_\_\_\_\_

Any medication 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 medically prescribed meal plan or dietary restrictions \_\_\_\_\_

Any allergies (food, drugs, plants, insects, etc.) \_\_\_\_\_

Any over-the-counter medications not to be given to camper while at camp \_\_\_\_\_

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!!**