PARTICIPANT HEALTH FORM 2008

(KEEP A COPY FOR YOUR RECORDS.) RETURN THIS FORM WITH YOUR BALANCE DUE BY JUNE 1, 2008

Last Name: ____________________ **First Name:** ____________________ Male ☐ Female ☐

Health/Accident Insurance: ____________________ Birth Date: ____________ Age: ______

Policy Number: ____________________ ☐ Copy Attached ☐ I have No Insurance

PLEASE CHECK ANY OF THE FOLLOWING WHICH HAVE OCCURRED TO THE CAMPER:

☐ Seizures / Convulsions	☐ Diabetes	☐ Cancer / Leukemia	☐ Mononucleosis	☐ Asthma
☐ Fainting / Dizzy Spells	☐ Heart disease / defect	☐ Bleeding / clotting disorder	☐ Altitude Sickness	☐ ADD / ADHD
☐ Head injury	☐ High blood pressure	☐ Menstrual problems	☐ Sleepwalking	☐ Bi-Polar
☐ Frequent headaches	☐ Frequent ear infections	☐ Kidney Disease	☐ Eating disorder	☐ ________

Explain: ____

MEDICATIONS:

☐ Does not take any medication regularly

☐ Takes medication (including vitamins) regularly

List all prescription & non-prescription meds:

____
____
____
____

(Please give details on the medication form.)
(Medications must be in the original container.)

ALLERGIES:

☐ No known allergies

☐ Medications: ____________

☐ Insect Stings: ____________

☐ Foods: ____________

☐ Other: ____________

Describe reaction & management: ________
____
____

SPECIAL DIET:

☐ None

Describe any special dietary restrictions / requirements

____
____
____
____
____
____

History of communicable disease, joint problems, emotional problems, surgery and/or serious illness or injury:

____
____

Physical disability or chronic illness that may limit the camper's activity:

____
____

THE FOLLOWING MUST BE COMPLETED BY A LICENSED PHYSICIAN OR A LICENSED NURSE PRACTICIONER.
THE EXAM MUST BE DONE WITHIN 24 MONTHS FROM THE BEGINNING OF CAMP.

If you have had a physical examination within 24 months prior to the dates you will be attending camp, a copy of the results may be attached to this form. If a copy is not available, a physical examination must be scheduled. **This includes youth & adults.**

A note to the examining physician: *The person being evaluated will be attending a week of camp that will include one or more of the following conditions: sleeping on the ground, vigorous group games, adventure challenge or wilderness hiking that may include high altitude, extreme weather conditions, cold water, exposure, fatigue and/or remote conditions where readily available medical care cannot be assured.*

General Appraisal:
____

Recommendations / Restrictions:
____
____

Precautions to be observed for activities at high altitudes? (9,000-12,000 ft)
____
____

Participant under physician's care for:
____
____

Prescribed treatment, medication, and diet to be continued at camp:
____
____

❑ Copy of Physical Attached

(For Girls & Women):

	Y	N
Has this person menstruated?	☐	☐
If not, has she been told about it?	☐	☐
If so, is her menstrual history normal?	☐	☐
Special considerations:		

Please complete the enclosed ***Colorado Health Department Certificate of Immunization***. For participants from out of state who are not "up to date" for Colorado standards, the parent/guardian may sign the personal exemption section.

❑ Copy of Immunization Records Attached

I have examined the person herein described and have reviewed the health history. It is my opinion that this camper is in satisfactory condition and capable of engaging in all camp activities, except as noted above.

Physicians Name (print) ____________________ **Physician Signature** ____________________

Address: ____________________ **Date examined:** ____________________

____________________ Phone: ____________________

Lutheran Ranches of the Rockies ✞ 805 S Shields St ✞ Fort Collins, CO 80521-3541
Phone: (970) 493-5258 ✞ Fax: (970) 493-7960

FOR OFFICE USE: **WEEK:** **ID:** ______ ❑ Screened w/in 24 hrs ❑ No signs of illness or injury ❑ No exposure to communicable disease in past 3 wks ❑ No additions or corrections ❑ Meds