Voyageurs Lutheran Ministry Health Form

Please print clearly. This form will be copied. Use a separate form for each camper.
Health information on this form is gathered to assist us in identifying appropriate care.

This form should be returned to the RLC Office by May 2, 2021

Register Online: rlcweb.myshelby.org

Camper Name _____ Date / Camp attending June 27-July 2

Gender _____ Birthdate _____ Age _____ Grade completed _____

Camper Address _____
City/State/Zip _____
Home Phone _____
Parent/Guardian _____
Parent work phone _____
Cell phone _____

Second Parent/Guardian _____
Home phone (if different) _____
Work phone _____
Cell phone _____
Emergency Contact Person _____
Phone _____

Allergies: *(check those which apply to this camper)*

_____ This camper has no known allergies

____ This camper has an allergy to the following food(s): _____

Describe the reaction if this food is eaten and what is done to manage it: _____

_____

_____ This camper is allergic to the following medication(s): _____

_____

_____ This camper is allergic to the following: _____

Describe the reaction and what is done to manage it: _____

_____

Diet: *Check those which apply to this camper. We will work meet any medical dietary restrictions but cannot cater to individual food preferences. Please call if you have a question about diet.*

_____ This camper eats a regular, varied diet.

_____ This camper eats this type of diet: ___ Gluten free
___ Semi-vegetarian (no beef or pork)
___ Vegetarian (no meat)
___ Vegan (no meat, eggs or dairy)

_____ This camper is lactose-intolerant. Check one:

_____ This camper uses a product like Lactaid and/or can self-manage the intolerance
_____ This camper needs a lactose-free diet that includes no lactose in baked items

Medication: *Provide complete information. Bring enough medication to last the entire session.* ***ALL*** *medication* ***MUST*** *be in original pharmacy containers and appropriately labeled.*

_____ This camper does not take routine medication.

____ This camper takes routine medication (including vitamins) as follows (attach more information if needed):

Name of medication _____ Name of medication

Reason for taking _____ Reason for taking

Dosage _____ Dosage

When med is taken _____ When med is taken

The following medications (or generic equivalents) are on hand in our Health Center. They are used and dispensed as directed by our medical protocols. *Cross out those which your child should* ***not*** *be given.*

Acetaminophen	*Benadryl tablets*	*Benadryl Cream*	*Ibuprofen*
Cough drops	*Alka-Seltzer*	*Tums*	*Cough Suppressant*
Cold/Sinus Medicine	*Eye drops*	*Chewable Tylenol*	*Children's Tylenol Cold*
Desitin Cream	*Aloe*	*Triple Antibiotic Cream*	*Hydrocortisone Cream*

Immunizations: *(please provide the month and year)*

_____ DPT Permanent Shots (series of 3)

_____ Tetanus Booster

_____ Polio Immunization

_____ MMR (Measles, Mumps, Rubella)

_____ Hepatitis B

_____ Haemophilus influenza b (Hib)

Swimming Ability:

_____ Non-swimmer

_____ Beginner - minimal swimming skills; avoids deep water

____ Intermediate - comfortable in deep water

General History: *Circle "yes" or "no" for each statement*

Has/does the camper:

Have asthma/wheezing/shortness of breath?	yes	no	Have difficulty hearing?	yes	no
Have diabetes?	yes	no	Have problems with falling asleep/sleepwalking?	yes	no
Had seizures?	yes	no	Have a history of bedwetting?	yes	no
Have headaches/migraines?	yes	no	Typically make noises while sleeping?(snores, talks, etc)	yes	no
Have frequent ear infections?	yes	no	Usually get up an night to use the bathroom?	yes	no
Had chicken pox?	yes	no	Wear glasses, contacts or protective eyewear?	yes	no
Had mononucleosis in the past 12 months?	yes	no	Recently been taken off a medication?	yes	no

For girls: knows about menstruation and/or has a normal menstrual history…….yes no

Please explain "YES" answers in the space below.

Restrictions:

_____ I have reviewed the program and activities of the camp and feel my child can participate without restrictions.

_____ I have reviewed the program and activities of the camp and fee my child can participate with the following restrictions or adaptations: (**Please describe below)**

What have we forgotten to ask? *Provide additional information about your child's health which may have been neglected on this form. Also, if there are life events or other things of which our staff should be aware regarding your child, please include them here.*

Name of Family Doctor _____ Phone _____

Insurance Information: In the event that your child needs to be seen by someone other than our Health Care Manager, it is helpful for us to have insurance information to pass onto the treating hospital or clinic.

Insurance Company _____ Policy Number _____

My child has permission to participate in all aspects of the program at Voyageurs Lutheran Ministry except as noted. I hereby give my permission to the physician selected by Voyageurs Lutheran Ministry to secure proper treatment, to hospitalized, to order injection, anesthesia, x-ray or surgery for my child as named above. Voyageurs Lutheran Ministry will make every effort to contact me if my child needs emergency medical-surgical treatment. I understand that my insurance has primary coverage and Voyageurs Lutheran Ministry insurance is secondary. I also give permission for any picture take of my child to be used for promotional purposes, including the VLM website and Facebook page.

Parent or Guardian signature _____ **date** _____