

# Rainbow Trail Lutheran Camp

## 2012 Health History & Examination Form

**CIRCLE ONE:** Intro Jr JrHi SrHi Conf Compass Pts.  
**CAMP DATES:** \_\_\_\_\_

**\*\* This side must be completed by parent/guardian of minors within 6 months prior to arrival at camp. Please notify Rainbow Trail in writing of any changes in this information between the time this form is completed and camp attendance. \*\***

**PLEASE PRINT**

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
 last first initial

Parent or Guardian (or spouse) \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_

Home Address/City/State/Zip \_\_\_\_\_ Email: \_\_\_\_\_

If not available in an emergency, notify \_\_\_\_\_ Relationship \_\_\_\_\_

Address/City/State/Zip \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Do you carry medical/hospital insurance? \_\_\_\_\_ If so, please indicate:  
 Carrier \_\_\_\_\_ Group/policy number \_\_\_\_\_

Name and phone number of dentist/orthodontist \_\_\_\_\_

Describe any emotional, learning, or psychological concerns and provide information to help us work effectively with this camper:

For minor females: Has this person menstruated? \_\_\_ If not, has she been told about it? \_\_\_ If yes, is menstrual history normal? \_\_\_

**CHRONIC CONCERNS**

- \_\_\_ None
- \_\_\_ Frequent ear infections
- \_\_\_ Heart disease/defect
- \_\_\_ Diabetes
- \_\_\_ Bleeding/clotting disorders
- \_\_\_ Hypertension
- \_\_\_ Asthma/Reactive Airway Disease
- \_\_\_ Seizures/Convulsions
- \_\_\_ Cerebral Palsy
- \_\_\_ Other \_\_\_\_\_

Provide information on each item checked:

\_\_\_\_\_  
 \_\_\_\_\_

**DISEASES:** (Date any that the camper has had)

- \_\_\_ Chicken pox      \_\_\_ German Measles
- \_\_\_ Mumps            \_\_\_ Hepatitis A
- \_\_\_ Measles           \_\_\_ Hepatitis B
- \_\_\_ Mononucleosis   \_\_\_ Hepatitis C

Describe any major illness, injury or surgery this camper has had in the past 2 years. \_\_\_\_\_

\_\_\_\_\_

**ALLERGIES**

- \_\_\_ No known allergies
- \_\_\_ Medications \_\_\_\_\_
- \_\_\_ Insect Stings \_\_\_\_\_
- \_\_\_ Foods \_\_\_\_\_
- \_\_\_ Other: \_\_\_\_\_

Describe reaction and management to any listed above:

\_\_\_\_\_  
 \_\_\_\_\_

**MEDICATIONS**

**\*\*Bring to camp in original container\*\***

List all medication (including vitamins) bringing to camp:

Name of medication \_\_\_\_\_  
 Reason for taking \_\_\_\_\_  
 Dosage \_\_\_\_\_  
 How often \_\_\_\_\_ Time of Day \_\_\_\_\_

Name of medication \_\_\_\_\_  
 Reason for taking \_\_\_\_\_  
 Dosage \_\_\_\_\_  
 How often \_\_\_\_\_ Time of Day \_\_\_\_\_

**FOR MORE MEDS, ATTACH ADDITIONAL SHEET**

My child has permission to participate in all camp activities, except as noted. I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests and treatment for the health of my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize or secure proper treatment (including surgery, injection, and/or anesthesia) for my child as named above.

Parent/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

Signature of witness \_\_\_\_\_ Date \_\_\_\_\_

Camper's signature \_\_\_\_\_ Date \_\_\_\_\_

**\*\* PHYSICIAN MUST COMPLETE THE BACK OF THIS FORM AND SIGN WITHIN 24 MONTHS OF CAMP DATE \*\***

**PLEASE KEEP A COPY OF THIS FORM**

WEEK OF CAMP: \_\_\_\_\_

**2012** \*\* This side to be filled out and signed by a licensed physician or licensed nurse practitioner. **2012**  
Colorado Law requires that a physical exam must occur within 24 months prior to arrival at camp\*\*

Name of Camper: \_\_\_\_\_ Date of examination: \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Temperature \_\_\_\_\_ Pulse \_\_\_\_\_ Respirations \_\_\_\_\_ Blood Pressure \_\_\_\_\_

This person is under the care of a physician for the following: \_\_\_\_\_

Treatment to be continued at camp: \_\_\_\_\_

Medications to be given at camp (include dosages & times): \_\_\_\_\_

Medically prescribed dietary restrictions: \_\_\_\_\_

Recommendations and restrictions on participation while in camp program: \_\_\_\_\_

What special precautions, if any, must be observed for activities at high altitudes? (Altitudes 8,000-14,000 ft) \_\_\_\_\_

**MUST BE COMPLETED FOR ALL PERSONS. REQUIRED BY COLORADO STATE LAW**  
**IMMUNIZATION VERIFICATION** Please give all dates of immunization for:

Vaccine:	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP		_____	_____	_____	_____	_____	_____
Tdap		_____	_____	_____	_____	_____	_____
Tetanus		_____	_____	_____	_____	_____	_____
Polio		_____	_____	_____	_____	_____	_____
MMR		_____	_____				
Or Measles		_____	_____				
Or Mumps		_____	_____				
Or Rubella		_____	_____				
Haemophilus influenza B		_____	_____	_____	_____	_____	_____
Hepatitis B		_____	_____				
Varicella (chicken pox)		_____	_____				

I have examined the above camp applicant, and found him/her to be in satisfactory condition, free from contagious diseases and capable of active participation in an active camp program.

Date examined: \_\_\_\_\_

Physician's signature: \_\_\_\_\_

Physician's Name (please print): \_\_\_\_\_

Address: \_\_\_\_\_  
Street and Number City State Zip

Phone: (\_\_\_\_) \_\_\_\_\_

- For use by camp health care provider (initial for compliance):
- \_\_\_\_\_ Health screening performed within 24 hours of camper's arrival.
- \_\_\_\_\_ No signs of illness or injury upon arrival at
- \_\_\_\_\_ No exposure to communicable disease in past 3 weeks.
- \_\_\_\_\_ No additions or corrections to information on health history.
- \_\_\_\_\_ Medications given to health care provider.

NOTES:

**Please return form to:**  
**Rainbow Trail Lutheran Camp**  
**107 South 9<sup>th</sup> Street, Ste. B**  
**Canon City, CO 81212**

**PLEASE KEEP A COPY OF THIS FORM**