



**2012 Compass Points
Physician's Release Health History and Examination Form**

**IMPORTANT
PLEASE READ
Before Conducting the Physical Exam**

Dear Doctor,

This person has registered to take part in a week long, wilderness adventure experience that includes three to five days backpacking with thirty plus pound packs for five to eight miles, in remote areas. The program may also include white-water rafting, rock climbing, service work, and/or high and low ropes course elements. These activities will occur at high altitudes, ranging from 8,500 to 14,000 feet. If you would like more information about specific program activities or environments please contact Ben Larson, Director of Compass Points, at 719-431-0050.

In order for this person to participate in this trip we require that a health history and physical exam be completed within 12 months of the trip dates. As you complete this exam we feel that it is important for you to take into consideration what affects the strenuous nature of activity and high altitude may have on this person and their ability to safely participate.

Please review the attached Health History and complete the Physical Examination Form, and talk with the patient about any concerns that you have for their participation. If you feel that this person is capable of safely participating in the above listed activities please complete the attached physical exam form.

PLEASE KEEP A COPY OF THIS FORM

Rainbow Trail Lutheran Camp – Compass Points 2012 Health History & Examination Form

Program: Compass Point

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 strenuous activities at high altitudes, and 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 12 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 12 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 strenuous activity at high altitudes and an active camp program.

Date examined: _____

Physician's signature: _____

Physician's Name (please print): _____

Address: _____
Street and Number City State Zip

Phone: (____) _____

Date of Form Completion _____ *By _____
*Initial if completed by nurse or physician's assistant.

- 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:

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