Dear Doctor,

This person has registered to take part in a week long wilderness adventure experience. This experience includes three to five days of backpacking with thirty plus pound packs for five to eight miles per day 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 how the nature of strenuous activity and high altitude may affect 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 activities listed above, please complete the attached physical exam form.
Rainbow Trail Lutheran Camp – Compass Points
2016 Health History & Examination Form

Program: Compass Points

** This side must be completed by parent/guardian of minors within 6 months prior to arrival at camp. **

Please notify RTLC in writing of any changes in this information between the time this form is completed and camp attendance.

### PLEASE PRINT

- **Name**
  - last name
  - first name
  - initial
  - Birthdate
  - Age
  - Sex

- **Parent or Guardian (or spouse)**
  - Home Phone: (_____)__________________
  - Work Phone: (_____)__________________
  - Email: ______________________________

- **Home Address/City/State/Zip**

- **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 ___________________________

#### ALLERGIES

- No known allergies
- Medications_________________________
- Insect Stings _______________________
- Foods______________________________
- Other: __________

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

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

#### 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**

### 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
COMPASS POINTS -- WEEK OF CAMP:

2016 ** This side to be filled out and signed by a licensed physician or licensed nurse practitioner. 2016

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_____ Respiration_____ 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:

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Dates: Mo/Yr</th>
<th>Mo/Yr</th>
<th>Mo/Yr</th>
<th>Mo/Yr</th>
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<td>Tdap</td>
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<td>Tetanus</td>
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<td>MMR</td>
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<tr>
<td>Or Measles</td>
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<tr>
<td>Or Mumps</td>
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<tr>
<td>Or Rubella</td>
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<tr>
<td>Haemophilus influenza B</td>
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<tr>
<td>Hepatitis B</td>
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<tr>
<td>Varicella (chicken pox)</td>
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</table>

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: ____________________________________________________________________________

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

______ 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 KEEP A COPY OF THIS FORM