2016 Compass Points
Health History and Physical Examination Form

Please Read
Before Conducting The Physical Exam

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.

PLEASE KEEP A COPY OF THIS FORM

Rainbow Trail Lutheran Camp – **Compass Points**
2016 Health History & Examination Form

Program: Compass Points
CAMP DATES:_____

**** 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_____ 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

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_____ 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
_____ 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