Rainbow Trail Lutheran Camp
2027 Health History & Examination Form

FAMILY CAMP WEEK #_____

PLEASE PRINT

Head of Household Name_____ Birthdate_____ Age_____ Sex_____
Last First
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_____

Please list each participant for item checked (Example: Mark letter A next to NONE if Participant A does not have any Chronic Concerns)

Name of Participant A _____ **Name of Participant D_____**
Name of Participant B_____ **Name of Participant E_____**
Name of Participant C_____ **Name of Participant F_____**

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:

_____

PLEASE KEEP A COPY OF THIS FORM

Rainbow Trail Lutheran Camp
2027 Family Camp Health Release Form

Family Name:_____

The participants listed below have 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 our participants, 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 our participants as listed below.

Parent/Guardian Signature_____ Date_____

Signature of Witness_____ Date_____

* * * * * * * * * * *

PLEASE PRINT
Name of Family Camp Participants (List more participants on the back of this form)

_____Birthdate_____Age_____Sex_____
Last First

_____Birthdate_____Age_____Sex_____
Last First

_____Birthdate_____Age_____Sex_____
Last First

_____Birthdate_____Age_____Sex_____
Last First

_____Birthdate_____Age_____Sex_____
Last First

_____Birthdate_____Age_____Sex_____
Last First

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