Camper Health Form
Summer 2025
One per Camper Please

camping & retreat center
LUTHER PARK
danbury, wisconsin

Camper Name _____Birthdate _____

Emergency Contacts:
#1 Name _____ Phone _____ Relation to Camper _____
#2 Name _____ Phone _____ Relation to Camper _____
#3 Name _____ Phone _____ Relation to Camper _____

Allergy & Dietary Restrictions
Does your child have any allergies?
- ☐ No
- ☐ Yes, allergic to: _____
  Allergic reaction details, date, and description: _____

Does your child require an EpiPen?
- ☐ No
- ☐ Yes. Please provide details about your child's anaphylaxis, including the date and description of last reaction. _____
  If marked "Yes" above, would you like your camper to carry their EpiPen on themselves throughout the day
  - ☐ Yes
  - ☐ No. I would like the Health Care Manager to carry my child's EpiPen.
  - ☐ No. I would like my child's Cabin Leader to carry my child's EpiPen.

Does your child have any dietary restrictions?
- ☐ No
- ☐ Yes, dietary restrictions include _____

Medications & Treatments
Will your child be taking any medications while at camp?
- ☐ No
- ☐ Yes. Medication _____ Dose _____ Time taken _____ Reason _____
  Medication _____ Dose _____ Time taken _____ Reason _____
  Medication _____ Dose _____ Time taken _____ Reason _____
  Medication _____ Dose _____ Time taken _____ Reason _____

If your child uses an Inhaler or Insulin, would you like them to carry it on themselves?
- ☐ Does not apply to my child.
- ☐ Yes
- ☐ No. I would like the Health Care Manager to carry my child's inhaler or insulin.
- ☐ No. I would like my child's Cabin Leader to carry my child's inhaler or insulin.

Will your child require any treatment while at camp?
- ☐ No
- ☐ Yes. Please explain: _____

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Does your child regularly take any medication that will not be taken at camp?

- □ No
- □ Yes. Please explain: _____

Check the following over-the-counter medications that MAY be given to your child while at camp, if needed?

- □ Acetaminophen (Tylenol)
- □ Antacids
- □ Antibiotic Cream
- □ Antihistamines (Benadryl, Diphenhydramine)
- □ ASA (Aspirin) Adults only unless directed by an MD.
- □ Calamine Lotion
- □ Hydrocortisone Cream
- □ Dimetapp
- □ Insect Repellent
- □ Pepto-Bismol
- □ Robitussin or cough drops
- □ Robitussin DM
- □ Sting Swabs
- □ Sudafed
- □ Sunburn Spray (Solarcaine) or Aloe Vera
- □ Sunscreen

Immunizations

Please list the date of your child's most recent vaccination or booster, if any, for the following

Tetanus Booster----------Immunized on _____ □ Not Immunized
Chicken Pox (Varicella)---------- Immunized on _____ □ Not Immunized
Diptheria, Tetanus, Pertussis (DTap)--Immunized on _____ □ Not Immunized
Polio---------- Immunized on _____ □ Not Immunized
MMR---------- Immunized on _____ □ Not Immunized
Haemophilus Influenza B---------- Immunized on _____ □ Not Immunized
Hep A---------- Immunized on _____ □ Not Immunized
Hep B---------- Immunized on _____ □ Not Immunized
Meningococcal Meningitis (MCV4)- Immunized on _____ □ Not Immunized
Pertussis/Tdap or Td booster---------- Immunized on _____ □ Not Immunized

Health History

Has your child experienced, or is currently experiencing, any of the following conditions?

ADD/ADHD □ No □ Yes. Please explain _____
Asthma/Inhaler □ No □ Yes, mild, moderate, or severe? Is it sports induced? _____
Bedwetting □ No □ Yes. Please explain _____
Behavioral Issues □ No □ Yes. Please explain _____
Blackouts/Fainting □ No □ Yes. Please explain _____
Bleeding Disorder □ No □ Yes. Please explain _____
Chest Pain □ No □ Yes. Please explain _____
Concussion □ No □ Yes. Please explain _____
Constipation/Diarrhea □ No □ Yes. Please explain _____
Convulsions □ No □ Yes. Please explain _____
Depression □ No □ Yes. Please explain _____
Developmental Delays □ No □ Yes. Please explain _____
Diabetes □ No □ Yes. Date of diagnosis & care needed _____
Eating Disorder □ No □ Yes. Please explain _____

Frequent Colds □ No □ Yes. Please explain _____
Headaches □ No □ Yes. Please explain _____

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Hearing Problems □ No □ Yes. Please explain _____
Heart Disease □ No □ Yes. Please explain _____
Homesickness □ No □ Yes. Please explain _____
Lice □ No □ Yes. Please explain _____
Mental Health Issues □ No □ Yes. Please explain _____
Nightmares/Terrors □ No □ Yes. Please explain _____
Problems Breathing or Coughing □ No □ Yes. Please explain _____
Seizures □ No □ Yes. Please explain _____
Skin Problems □ No □ Yes. Please explain _____
Sleepwalking □ No □ Yes. Please explain _____
Speech Problems □ No □ Yes. Please explain _____
Stomach Aches □ No □ Yes. Please explain _____

Has your child had any operations?

□ No
□ Yes. Please explain _____

Has you child ever been hospitalized or had a serious injury?

□ No
□ Yes. Please explain & list date(s) _____

Has you child been exposed to any communicable diseases within the last 3 months?

□ No
□ Yes. Please explain & list date(s) _____

Does your child have any restrictions on activity?

□ No
□ Yes. Please explain _____

Will you child require and special assistance while at camp?

□ No
□ Yes. Please explain _____

Please list any other medical information the camp should know about your child & if you would like to discuss anything with the medical staff.

_____
_____

Health Insurance and Doctor Information

Family Doctor _____ Phone Number _____
Family Dentist _____ Phone Number _____

Do you have medical insurance? □ No □ Yes

Health Insurance Policy Holder Information

Full name of Policy holder _____ Policy holder phone _____
Employer name (if through employer) _____

Health Insurance Company Information

Insurance Company/Plan Name_____ Insurance company phone _____
Health Insurance Policy Number _____ Insurance group name or number _____

Camper Name _____

Medical Waiver

My child has permission to engage in all camp activities, except as noted by myself and the examining physician. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Camp Director to hospitalize, secure proper treatment for, to order injection, anesthesia or surgery for my child as named above. I give permission for the camp to provide routine healthcare and dispense medications. I voluntarily waive any claim against the sponsoring institution, local churches and camp personnel for any mishap or lost articles, or any and all causes which may arise in connection with activities of Luther Park Camping and Retreat Center.

_____ _____
Parent/Guardian Signature Date