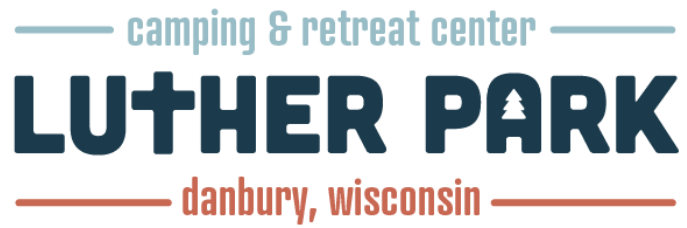


Camper Health Form  
Summer 2026  
One per Camper Please



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: \_\_\_\_\_

Camper Name \_\_\_\_\_

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?

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

### Immunizations

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

- |   |                    |  |
|---|--------------------|--|
| Tetanus Booster-----                    | Immunized on _____ | <input type="checkbox"/> Not Immunized |
| Chicken Pox (Varicella)-----            | Immunized on _____ | <input type="checkbox"/> Not Immunized |
| Diphtheria, Tetanus, Pertussis (DTap)-- | Immunized on _____ | <input type="checkbox"/> Not Immunized |
| Polio-----                              | Immunized on _____ | <input type="checkbox"/> Not Immunized |
| MMR-----                                | Immunized on _____ | <input type="checkbox"/> Not Immunized |
| Haemophilus Influenza B-----            | Immunized on _____ | <input type="checkbox"/> Not Immunized |
| Hep A-----                              | Immunized on _____ | <input type="checkbox"/> Not Immunized |
| Hep B-----                              | Immunized on _____ | <input type="checkbox"/> Not Immunized |
| Meningococcal Meningitis (MCV4)-        | Immunized on _____ | <input type="checkbox"/> Not Immunized |
| Pertussis/Tdap or Td booster-----       | Immunized on _____ | <input type="checkbox"/> 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 \_\_\_\_\_

**Camper Name** \_\_\_\_\_

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 your child ever been hospitalized or had a serious injury?

No

Yes. Please explain & list date(s) \_\_\_\_\_

Has your 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 your 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