

# CAMP LUTHER HEALTH HISTORY & EMERGENCY FORM

Name: \_\_\_\_\_ Date and Camp/Event: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell/Work: \_\_\_\_\_

Secondary Contact: \_\_\_\_\_

Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell/Work: \_\_\_\_\_

Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist/Orthodontist: \_\_\_\_\_ Phone: \_\_\_\_\_

Health Insurance Carrier (or attach card): \_\_\_\_\_

Address: \_\_\_\_\_

Policy #: \_\_\_\_\_ Phone: \_\_\_\_\_

Known Medical Conditions: (If camper is prone to headaches, injury, etc. please send appropriate medication with instructions.)

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Please list any current medications and why being taken:

(Must be in original container, these will be collected and distributed per instructions.)

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Are there any dietary restrictions we need to know about?

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Up to date on immunizations? Yes: \_\_\_ No: \_\_\_ Date of last tetanus shot: \_\_\_\_\_

This health history is correct and accurate as far as I know, and the person described herein has permission to engage in all prescribed camp activities except as noted. I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for this person. In the event I cannot be reached in an emergency, I hereby give my permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named. I allow this person's picture/video to be taken for use in promotion and publicity efforts of Camp Luther of Nebraska, Inc. unless this statement is crossed out.

**Signature of parent or Guardian (or self if over 18)**

**X** \_\_\_\_\_ **Date:** \_\_\_\_\_