Lutherwood
CAMP AND RETREAT CENTER

Dates will attend camp: _____ to _____
Month/Day/Year Month/Day/Year

_____ DOB: _____
Camper Name Month/Day/Year

□ Male □ Female Age on arrival at camp: _____

1185 Roy Road
Bellingham, WA 98229
Phone: (360) 734-7652
Fax: (360) 734-7682
program@camplutherwood.org

To parent(s) / guardian(s):

- Please have your camper's physician review, complete, and sign this form.
- Please make a copy (front and back) of your insurance card and attach to this form.
- Please make a copy of your camper's immunization record and attach to this form.
- Please mail, fax ((360)734-7682), or bring your camper's completed med form to check-in.

Camper Home Address | City | State | Zip Code

Parent/Guardian Name | Relationship to Camper | Preferred Phone Number

Parent/Guardian Address (if different) | City | State | Zip Code

Additional Parent/Guardian Name | Relationship to Camper | Preferred Phone Number

Emergency Contact Name | Relationship to Camper | Preferred Phone Number

Allergies: □ No known allergies
This camper is allergic to: □ Food □ Medicine □ The environment (insect stings, hay fever, etc.) □ Other
Please describe below what the camper is allergic to and the reaction seen.

Diet, Nutrition: □ This camper eats a regular diet.
□ This camper eats a regular vegetarian diet. □ This camper has special food needs. ***Please describe below.***

Restrictions:
□ I have reviewed the program and activities of Lutherwood and feel the camper can participate without restrictions.
□ I have reviewed the program and activities of Lutherwood and feel the camper can participate with the following restrictions. ***Please describe below.***

Insurance:

_____ / _____ | _____ | _____
Insurance Carrier / Subscriber | Insurance Phone Number | Policy Number

Medications:

□ This camper will not take any daily medications while attending camp.

□ This camper will take the following daily medication(s) at camp.

A "medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins and natural remedies. Please bring your camper's medications in a Ziploc baggie with their name written on it in Sharpie. Please make sure your camper has enough medication to last the entire time the camper will be at Lutherwood.

Name of Medication	Date Started	Reason for Taking It	When It Is Given	Amount or Dose Given	How It Is Given
			□ Breakfast □ Lunch □ Dinner □ Bedtime □ As Needed □ Other: _____		
			□ Breakfast □ Lunch □ Dinner □ Bedtime □ As Needed □ Other: _____		
			□ Breakfast □ Lunch □ Dinner □ Bedtime □ As Needed □ Other: _____		
			□ Breakfast □ Lunch □ Dinner □ Bedtime □ As Needed □ Other: _____		

The following non-prescription medications may be stocked in the camp Med Shed and are used on an as needed basis to manage illness and injury. Cross out those the camper should not be given.

Acetaminophen (Tylenol)
Ibuprofen (Advil, Motrin)
Phenylephrine decongestant (Sudafed PE)
Pseudoephedrine decongestant (Sudafed)
Antihistamine/allergy medicine
Gualfenesin cough syrup (Robitussin)
Diphenhydramine antihistamine/allergy medicine (Benadryl)
Dextromethorphan cough syrup (Robitussin DM)
Sore throat spray
Generic cough drops
Lice shampoo or cream (Nix or Elimite)
Antibiotic cream
Calamine lotion
Aloe
Laxatives for constipation (Ex-Lax)
Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismal)

Immunizations:

Please make a copy of your camper's immunizations record and attach it to this form to be turned in.

If your camper has not been fully immunized, please sign the following statement: *I understand and accept the risks to my child from not being fully immunized.*

_____ _____ _____

Parent/Guardian Signature | Date | Relationship to Camper

General Health History: *Check "Yes" or "No" for each statement. Explain "Yes" answers below.*

Has/does the camper:

1. Ever been hospitalized? ……..……..... □ Yes □ No
2. Ever had surgery? ……..……..... □ Yes □ No
3. Have recurrent/chronic illnesses? ……..…….. □ Yes □ No
4. Had a recent infectious disease? ……..……..... □ Yes □ No
5. Had a recent injury? ……..……..... □ Yes □ No
6. Had asthma/wheezing/shortness of breath? ..... □ Yes □ No
7. Have diabetes? ……..……..... □ Yes □ No
8. Had seizures? ……..……..... □ Yes □ No
9. Had headaches? ……..……..... □ Yes □ No
10. Wear glasses, contacts, or protective eyewear? .... □ Yes □ No
11. Had fainting or dizziness? ……..……..... □ Yes □ No
12. Passed out/had chest pain during exercise? ..... □ Yes □ No
13. Had mononucleosis during the past 12 months?..... □ Yes □ No
14. If female, have problems with menstruation? ……..……..... □ Yes □ No
15. Have problems with falling asleep/sleepwalking?..... □ Yes □ No
16. Ever had back/joint problems? ……..……..... □ Yes □ No
17. Have a history of bedwetting? ……..……..... □ Yes □ No
18. Have problems with diarrhea/constipation? ……..……..... □ Yes □ No
19. Have any skin problems? ……..……..... □ Yes □ No
20. Traveled outside the country in the past 9 months?..... □ Yes □ No

Mental, Emotional, and Social Health: *Check "Yes" or "No" for each statement. Explain "Yes" answers below.*

Has the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? ……..……..... □ Yes □ No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder? ……..……..... □ Yes □ No
3. During the past 12 months, seen a professional to address mental/emotional health concerns? ……..……..... □ Yes □ No
4. Had a significant life event that continues to affect the camper's life? ……..……..... □ Yes □ No

(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Health-care Providers:

Name of Camper's Primary Care Doctor(s) _____ Phone Number _____

Name of Camper's Dentist _____ Phone Number _____

What Have We Forgotten to Ask? *Please provide in the space below any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program.*

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physicians selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Parent/Guardian Signature _____ Date _____ Relationship to Camper _____

Physician's Printed Name _____ Physician's Signature _____ Date _____