



2009 Summer Camp Health Form

(Please notify NLR in writing if any of the information on this form changes before camp.)

Camper Name: _____ Week: _____

HEALTH HISTORY

(Check, if applies. Give approximate dates.)

- _____ Frequent Ear Infections
- _____ Heart Defect/Disease
- _____ Convulsions/Epilepsy
- _____ Diabetes
- _____ Bleeding/Clotting Disorders
- _____ Hypertension
- _____ A.D.D./A.D.H.D
- _____ Mononucleosis
- _____ Bedwetting
- _____ Sleepwalking
- _____ Mononucleosis
- _____ Bedwetting
- _____ Sleepwalking
- _____ Chicken Pox
- _____ Measles
- _____ German Measles
- _____ Mumps

Food Allergies: _____

ALLERGIES (Dates not needed)

- _____ Hay Fever
- _____ Ivy Poisoning, etc. (see below)
- _____ Insect Stings (see below)
- _____ Asthma
- _____ Penicillin
- _____ Other Drugs

List: _____

Is allergy severe enough to keep your child from participating from activities in the woods?
Yes _____ No _____

Family physician: _____ Phone: (____) _____ Dentist/Orthodontist: _____ Phone: (____) _____

Disabilities, recurring illnesses, psychological conditions we should be aware of (give dates): _____

Activities limited by a physician: _____

Any dietary restrictions? _____

(NLR will not provide special meals, but we will inform our staff of a camper's restrictions and help them choose allowed foods from our regular menu.)

List any medication to be administered at camp & diagnosis or reason for taking (specific times & doses): _____

****NO MEDICATION WILL BE GIVEN WITHOUT SPECIFIC ADMINISTRATION INSTRUCTIONS**** (All medication must be turned into the nurse upon arrival at camp. Campers will not be allowed to have medication in their cabin.)

FOR FEMALES (next two lines):

Has she menstruated? _____ If not, has she been told about it? _____ If so, is her menstrual history normal? _____

Special Instructions? _____

Immunizations current? (circle one) Yes No Date of last tetanus booster: ____/____/____ Date of last physical exam ____/____/____

CAMPER PROFILE – please fill out the information below to help our counselors.

Has the camper been affected by a death, divorce or traumatic experience recently (or is still dealing with one of these situations)? If so, please explain: _____

What three words describe your camper's personality? _____

Is your child a Christian? If so, what role does Christ play in his/her life, if any? _____

Special concerns or needs that you have as a parent regarding your camper while he/she is at camp? _____

What do you desire your camper to gain from camp? _____

What does your camper want to gain from camp? _____

INSURANCE INFORMATION: Note here if you don't have insurance: **Health Insurance Carrier:** _____

Insurance Mailing Address: (Street, City, State, Zip) _____

Group #: _____ Policy #: _____ Co-Pay Amt: \$ _____ Deductible Amt: \$ _____

Primary Policy Holder Name: _____ Policy Holder ID (SSN): _____ Policy Holder Date of Birth: ____/____/____

Policy Holder Employer: _____ Camper Insurance ID (SSN): _____ Camper Date of Birth: ____/____/____

PLEASE READ CAREFULLY: I hereby attest that I have read and reviewed this form and have completed it accurately and will report any information that may change. I therefore agree that this child may participate in all camp activities including travel off of the property. Also, I give permission for NLR to use images and recordings of my child/ward without further compensation. I realize that in the event of an illness or injury while at camp or while participating in it's activities, medical treatment may be required. I give permission for the medical personnel selected by the camp director to order any medical procedures, including x-rays, routine tests, treatment, hospitalization and transportation. Furthermore, I agree to bear the cost of all such treatment. I also agree to hold harmless New Life Ranch, it's staff, and board of directors from any and all liabilities, claims, demands and causes of action whatsoever which may arise due to the participation of myself or this child in said activities.

And for our camp Doctor, Community Physicians Group:

I hereby authorize payment directly to Community Physicians Group and any consulting physicians insurance benefits otherwise payable to me or my minor dependents. I understand that I am financially responsible for charges not covered by this authorization. I hereby authorize release of information requested of Community Physicians Group and any consulting physician. I further agree to allow Community Physicians Group to release medical information on me or any of my minor dependents if requested by any insurance company for purpose of determining benefits payable.

Parent/Guardian Signature: _____ Date: _____