Lakeshore Center at Okoboji HEALTH INFORMATION FORM

This form and a copy of your camper's immunization record are REQUIRED for camp attendance.

Camper Name _____ Birth Date ____/____/_____

Contact information:

Parent or Guardian 1:

Name: _____

Home Phone Number: _____

Cell Phone: _____

Work phone: _____

Parent or Guardian 2 (if applicable)

Name: _____

Home Phone Number: _____

Cell Phone: _____

Work phone: _____

Emergency Contact: (in the event a parent or guardian cannot be reached)

Name: _____ Relationship to Camper: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Insurance information

Person responsible for Insurance Coverage: _____

Health Insurance Carrier: _____

Policy Number: _____ Group Number: _____

Insurance Billing Address: _____

City: _____ State: _____ Zip: _____

Physician information

Personal Physician Name: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Date of last physical exam: (Month, Year) _____

Camper's Health Information

Height: ___Feet ___ Inches

Weight: _____Pounds

General Health Condition (check one):

____Excellent ____Good ____Fair ____Poor

Allergies: ___None ___ Peanuts ___Milk ___Eggs ___Tree Nuts ___Wheat ___Seasonal ___Penicillin ___Sulfa drugs ___Other (please list): _____

Dietary restrictions: ___None ___Peanuts ___Milk ___Eggs ___Tree Nuts ___Wheat ___Vegetarian ___Vegan ___Gluten-free ___Other (please list): _____

Does your camper have any **restrictions on camp activities**? (strenuous activity, heavy lifting, etc) ____No ____Yes (please list):

_____

Immunizations required for school are up to date. ____Yes ____No **Copy of current immunization record is REQUIRED**

Date of last Tetanus shot: (Month, Year) _____

Recent illness, injuries, or surgeries (what, when): _____

_____

Recent exposure to contagious or infectious disease (what, when): _____

_____

(More on next page —>)

History of, or presently under the care for (Check all that are appropriate):

____ Asthma ____ Arthritis ____Bronchitis ____ Heart Condition ____ Skin disease
____ Digestive Disorder ____ Tonsillitis ____ Epilepsy/Seizures ____ Diabetes ____ Eating Disorder
____ ADD/ADHD ____ Anxiety ____ Depression ____ Bipolar ____Other (please list below):

_____

Current Medications (Please list all medications taken regularly, if you require more space, include on a separate sheet)**:**

Medication Name	**Dosage**	**Purpose**	**Schedule**	**Taking at Camp**
_____	_____	_____	_____	___Yes ___No
_____	_____	_____	_____	___Yes ___No
_____	_____	_____	_____	___Yes ___No

Any medication taken to camp MUST BE BROUGHT IN ORIGINAL CONTAINERS and turned in to camp staff at check-in.

Are there any medications your camper should **NOT** be given? (Aspirin, throat lozenge, laxative, antacid, etc…)

_____

If female, has menstruation begun? ____Yes ____No If no, has she been told about it? ____Yes ____No

Camper is subject to:

____ Homesickness ____ Headaches ____ Cramps ____ Sleepwalking ____ Rashes/Hives
____ Ear Aches ____ Bedwetting ____ Stomach Aches ____ Nosebleeds ____ Swimmers' Ear
____ Seasonal Allergies ____ Picky Eating ____ Growing Pains ____ Tantrums ____ Dehydration
____ Other (Please List):_____

Please list any current physical, emotional, or psychological conditions which may require special considerations while at camp.

_____

_____

Are there any significant traumatic events in the camper's life in the past year? (divorce, death in family, emergency, etc.)

_____

_____

Please let us know anything else about your camper that would help us to make his/her camp experience the best possible:

_____

_____

In signing this document, I, _____ (print your full name), hereby certify that all the information contained is correct and give permission for the use of photographs including my child to be used in camp publicity.

My Camper, _____ (Camper's full name), has my/our permission to participate in camp. I/we understand that all camp activities will be closely supervised and that medical and/or hospital care will be given if serious illness or injury occurs. I hereby give permission to the medical personnel selected by the camp to provide routine health care; to administer medications, First Aid, and acetaminophen; to order x-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

*_____ Date: _____

(Signature of Parent/Guardian)

PLEASE RETURN THIS FORM TO THE LAKESHORE OFFICE BY JUNE 1st

1864 Hwy. 86, Milford, IA 51351

LAKESHORE Center at OKOBOJI