2016-2017 LUTHER SPRINGS RETREAT
ADULT HEALTH FORM

PLEASE COMPLETE THE ENTIRE FORM AND TURN IN AT CHECK-IN

Name_____
Last First MI

Birth Date_____Age_____ Male___ Female ____

Home Address_____City_____State_____Zip_____

Home Phone _____ Cell Phone_____Email_____

Emergency Contact #1_____Relationship_____

Home Address_____City_____State_____Zip_____

Home Phone _____ Cell Phone_____Addtl Phone_____

Emergency Contact #2_____Relationship_____

Home Address_____City_____State_____Zip_____

Home Phone _____ Cell Phone_____Addtl Phone_____

Physician Name_____Phone_____

Dentist Name_____Phone_____

Health Insurance Information

Luther Springs does not provide participant sickness insurance but does have secondary accident insurance. The participant is responsible for all charges associated with an accident or illness.

Carrier Name_____
Carrier Address_____
Policy # _____Phone_____
Policy Holder's Name_____
Policy Holder's Date of Birth_____
If you have an Rx card Bin #_____ID#_____Group #_____

THE PERSON HEREIN DESCRIBED HAS PERMISSION TO ENGAGE IN ALL CAMP ACTIVITIES EXCEPT AS NOTED

I hereby give permission to Luther Springs to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests on my behalf. I agree to the release of any records necessary for insurance purposes. I give permission for the camp to arrange necessary, related transportation for me.

In the event my Emergency Contact cannot be reached, I hereby give permission to the Health Care provider selected by the camp to secure and administer treatment, including hospitalization, on my behalf. This completed form may be photocopied for trips off camp.

Printed Name_____ Signature_____Date_____

HEALTH HISTORY:	Yes	No			
Recent injury, illness or infectious disease	❑	❑	Have/ever had high blood pressure	❑	❑
Have a chronic/recurring illness/condition	❑	❑	Ever passed out during or after exercise	❑	❑
Have frequent headaches	❑	❑	Ever had chest pain during or after exercise	❑	❑
Ever had a head injury	❑	❑	Ever had seizures	❑	❑
Ever had an operation	❑	❑	Have diabetes	❑	❑
Ever have problems with joints	❑	❑	Have asthma	❑	❑

Please explain and "yes" responses_____

_____

_____

_____

Please indicate the date of the last immunizations/booster for:

DTP_____ MMR_____ TD (Tetanus)_____Hepatitis B_____ HIB_____

Have you ever had any of the following: Measles_____ Chicken Pox _____ Mumps _____ German Measles ____

Medication Allergies (Please note reaction)_____

_____

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_____

Are there any special health concerns of which any medical provider should be aware:_____

_____

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_____

Please list all current medications including name of medication, dosage, prescribing doctor and their contact information. A list can be attached. _____

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Environmental Allergies_____

_____

Nutrition/dietary restrictions_____

_____

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