



2017-2018 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 a chronic/recurring illness/condition
Have frequent headaches
Ever had a head injury
Ever had an operation
Ever have problems with joints

Have/ever had high blood pressure
Ever passed out during or after exercise
Ever had chest pain during or after exercise
Ever had seizures
Have diabetes
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) _____

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

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

Environmental Allergies _____

Nutrition/dietary restrictions _____

