



## 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/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) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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 \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_