Voyageurs Lutheran Ministry Health Form

Please print clearly. This form will be copied. Use a separate form for each participant.
Health information on this form is gathered to assist us in identifying appropriate care.
Two copies of this form should be returned to Camp Vermilion at least 4 weeks before your trip.

Participant Name_____ Canoe Trip Dates _____

Gender _____ Birthdate _____ Age _____ Grade completed (if applicable)_____

Address _____

City/State/Zip _____

For participants under 18 years of age

Parrent/Guardian _____

Cell/Home phone_____

Work phone _____

Emergency Contact Person _____

Relation to Participant _____

Cell/Home phone _____

Work phone _____

Family Doctor _____

Phone _____

Allergies: *(check those which apply to this participant)*

____ This participant has no known allergies

____ This participant has an allergy to the following food(s): _____

Describe the reaction if this food is eaten and what is done to manage it: _____

_____

____ This participant is allergic to the following medication(s): _____

_____

____ This participant is allergic to the following: _____

Describe the reaction and what is done to manage it: _____

_____

Diet: *Check those which apply to this participant. We will work meet any medical dietary restrictions but cannot cater to individual food preferences. Please call if you have a question about diet.*

____ This participant eats a regular, varied diet.

____ This participant eats this type of diet:

__ Gluten free
__ Semi-vegetarian (no beef or pork)
__ Vegetarian (no meat)
__ Vegan (no meat, eggs, or dairy)
__ Dairy free
__ Lactose-intolerant, self-managed

Medication: *Provide complete information. Bring enough medication to last the entire trip.* ***ALL*** *medication* ***MUST*** *be in original pharmacy containers and appropriately labeled.*

____ This participant does not take routine medication.

____ This participant takes routine medication (including vitamins) as follows (attach more information if needed):

Name of medication _____ Name of medication _____

Reason for taking _____ Reason for taking _____

Dosage _____ Dosage _____

When med is taken _____ When med is taken _____

The following medications (or generic equivalents) are on hand and/or in our Health Center. They are used and dispensed as directed by our medical protocols. *Cross out those which your child should* ***not*** *be given.*

Acetaminophen	*Benadryl tablets*	*Benadryl Cream*	*Ibuprofen*
Cough drops	*Alka-Seltzer*	*Tums*	*Cough Suppressant*
Cold/Sinus Medicine	*Eye drops*	*Chewable Tylenol*	*Children's Tylenol Cold*
Desitin Cream	*Aloe*	*Triple Antibiotic Cream*	*Hydrocortisone Cream*

Participant Name: _____

Immunizations: *(please provide the month and year)*

_____ Tetanus Booster

For participants under 18 years of age:

_____ DPT Permanent Shots (series of 3)
_____ Polio Immunization
_____ MMR (Measles, Mumps, Rubella)
_____ Hepatitis B
_____ Haemophilus influenza b (Hib)

Swimming Ability:

____ Non-swimmer
____ Beginner - minimal swimming skills; avoids deep water
____ Intermediate - comfortable in deep water

Insurance Information: In the event that this participant needs to be seen by someone other than our staff, it is helpful for us to have insurance information to pass on.

Insurance Company _____
Policy number _____

General History: *Circle "yes" or "no" for each statement*

Has/does the participant:

Have asthma/wheezing/shortness of breath? yes no
Have diabetes? yes no
Had seizures? yes no
Have headaches/migraines? yes no
Have frequent ear infections? yes no
Had chicken pox? yes no
Had mononucleosis in the past 12 months? yes no

For girls: knows about menstruation and/or has a normal menstrual history……yes no

Have difficulty hearing? yes no
Have problems with falling asleep/sleepwalking? yes no
Have a history of bedwetting? yes no
Typically make noises while sleeping? (snores, talks, etc) yes no
Usually get up an night to use the bathroom? yes no
Wear glasses, contacts or protective eyewear? yes no
Recently been taken off a medication? yes no

Please explain "YES" answers in the space below.

Restrictions:

_____ I have reviewed the program and activities of this trip and this participant can participate without restrictions.

_____ I have reviewed the program and activities of the trip and feel this participant can participate with the following restrictions or adaptations: (**Please describe below)**

What have we forgotten to ask? *Provide additional information about the participant's health which may have been neglected on this form. Also, if there are life events or other things of which our staff should be aware regarding this participant, please include them here.*

For adult participants: To the best of my knowledge, the information provided on this form is correct, and I am able to participate in all aspects of the program at Voyageurs Lutheran Ministry except as noted. I understand that my health information will be shared with appropriate camp staff. I agree to inform the camp of any changes that might impact my participation. In the event that I (or my spouse) cannot make a decision in an emergency, I hereby give my permission to the physician selected by Voyageurs Lutheran Ministry to secure proper treatment, to hospitalized, to order injection, anesthesia, x-ray or surgery for myself as named in this form. I understand that my insurance has primary coverage and Voyageurs Lutheran Ministry insurance is secondary. I also give permission for any picture taken of me to be used for promotional purposes, including the VLM website and Facebook page.

Signature_____ **date** _____

For participants under 18 years of age: My child has permission to participate in all aspects of the program at Voyageurs Lutheran Ministry except as noted. I hereby give my permission to the physician selected by Voyageurs Lutheran Ministry to secure proper treatment, to hospitalized, to order injection, anesthesia, x-ray or surgery for my child as named above. Voyageurs Lutheran Ministry will make every effort to contact me if my child needs emergency medical-surgical treatment. I understand that my insurance has primary coverage and Voyageurs Lutheran Ministry insurance is secondary. I also give permission for any picture taken of my child to be used for promotional purposes, including the VLM website and Facebook page.

Parent or Guardian signature _____ **date** _____