Voyageurs Lutheran Ministry
Adult Health History
Please print clearly. This form will be copied.

Name _____ Gender _____ Birthdate _____

Address _____

City/State/Zip _____

Primary Phone _____ Secondary Phone _____

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

____ I have no known allergies

____ I am allergic to the following food(s): _____

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

_____

____ I am allergic to the following medication(s): _____

_____

____ I am allergic to the following: _____

Describe the reaction and what is done to manage it:

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

____ I eat a regular, varied diet.

____ I eat this type of diet:
- __ Gluten free
- __ Semi-vegetarian (no beef or pork)
- __ Vegetarian (no meat)
- __ Vegan (no meat, eggs or dairy)

____ I am lactose-intolerant. Check one:
- ____ I use a product like Lactaid and/or can self-manage the intolerance
- ____ I need a lactose-free diet that includes no lactose in baked items

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

____ I do not take routine medication.

____ I take routine medication (including vitamins) as follows (attach more information if needed):

Name of medication _____ Dosage _____

Name of medication _____ Dosage _____

Name of medication _____ Dosage _____

Name of medication _____ Dosage _____

What have we forgotten to ask? *Provide additional information about your health which may have been neglected on this form, or additional information of which our staff should be aware.*

Emergency Contact:

Should the unforeseen occur, who would you like us to notify in an emergency?

Name _____ Relation to you _____

Preferred Phone: _____ Alternate phone _____

Alternate contact _____ Relation to you _____

Preferred Phone:_____ Alternate phone _____

Insurance Information: In the event of an accident that requires medical attention it may be helpful for us to have insurance information to pass onto the treating hospital or clinic.

Insurance Company _____ Policy number _____

Statement of Agreement

To the best of my knowledge, the information provided on this form is correct, and I am able to participate in all camp activities (with the above noted exceptions). I understand that my health information will be shared with camp staff on a "need to know" basis and that, as an adult, I retain primary responsibility for managing my health status while at camp. 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 hearby give my permission to the physician selected by Voyageurs Lutheran Ministry to secure proper treatment for, and to order injection, anesthesia, 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 take of me to be used for promotional purposes, including the VLM website and Facebook page.

Signature _____ date _____