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**FLBC Camp Medical Information Form**

**Please complete a camper medical form for each camper and attest to it being accurately filled out by signing at the end.**Camper Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Camp Session attending at Flathead Lutheran Bible Camp: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinic/Office Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s Phone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Note: Flathead Lutheran Bible Camp’s insurance is secondary to the camper’s own health and accident insurance. In case of an accident or injury, the camper’s parents’ or guardian’s insurance will be the primary coverage.

Does this camper have Health Insurance: Yes \_\_\_\_\_ No \_\_\_\_

Insurance Provider (type N/A if not applicable)
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Policy Number (Type N/A if not applicable)
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Group/ID (type N/A if not applicable)
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insurance Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diet and Nutrition:

\_\_Regular \_\_Vegetarian \_\_Vegan \_\_Lactose Intolerant

\_\_ Other (please describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This Camper is free from illness, injury, or surgery which would affect participation:

\_\_\_ Yes \_\_\_ No

If No, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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**General History (Please select all that apply)**

\_\_ Mononucleosis? \_\_Chicken Pox? \_\_ Measles \_\_ German Measles

\_\_ Mumps \_\_ Abnormal Hearing \_\_ Abnormal Vision \_\_Asthma

\_\_Diabetes \_\_Heart Defect/Disease \_\_Seizure Disorder \_\_Headaches

\_\_Hypertension \_\_Sleep-Walking \_\_Bleeding/Clotting disorder

\_\_ Bed Wetting \_\_Frequent Ear Infections \_\_Frequent Colds

\_\_ Frequent Nighttime Bathroom Use \_\_ Making Noise when Sleeping

\_\_For Females, been told about Menstruation \_\_For Females, has Menstrual Cramps

\_\_For Females, has Regular Periods \_\_None

For any “yes” responses above, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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**Mental, Emotional and Social Health (Please Select All that Apply)**

\_\_ Emotional Health Concerns

\_\_ Learning Disability

\_\_ Diagnosed with Attention Deficit Disorder (ADD or ADHD)

\_\_ Under Professional Care for Emotional or Mental Concerns

\_\_ Diagnosed with Depression, Panic or Anxiety Disorder, or OCD

\_\_ None

Please explain “yes” responses above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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**Immunizations:**

Are your camper’s immunizations up to date? \_\_ Yes \_\_ No **Medications:**All medications must be in the original pharmacy containers and labeled appropriately. Campers MUST turn in all medications, vitamins, and over-the-counter drugs to the Camp Nurse upon arrival. For the safety of your child and other campers, self-medicating is NOT allowed. Our trained first-aid staff will administer typical over the counter medication as necessary unless noted under allergies.

Allergies: \_\_ No Known Allergies \_\_ Drug

 \_\_ Food \_\_ Environmental

Please list all allergies and reactions below: (if none, please state N/A)
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What have we forgotten to ask? Please provide in the space below any additional information about the individuals health that you think important or that may affect the individuals ability to fully participate in the camp program:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian:

I have reviewed my camper’s medical form and attest to it being accurately filled out.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Signature of parent/guardian Date of Signature