



FLBC Medical Information Form-2021

Please complete a camper medical form for each camper and attest to it being accurately filled out by signing at the end. If you choose, please also sign the "Permission to Treat" at the end of the form.

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 Intolerante

Other (please describe) _____

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

Yes No

If No, please describe: _____

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

Please provide any helpful context about what you selected above: _____

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
- Diagnosed with Autism
- None

Please provide any helpful context about what you selected above: _____

Immunizations:

Is your camper up to date with all immunizations required for them to attend school, according to your camper’s home state? ___yes ___No

Please state the date (Month/Year) of your camper’s most recent tetanus shot? _____

*If your camper is exempted for personal, medical, or religious reasons, you must include the completed legal exemption document from your home state.

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 individual’s health that you think important or that may affect the individual’s ability to fully participate in the camp program:

ACKNOWLEDGEMENT 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

PARENT/GUARDIAN PERMISSION FOR HEALTH CARE PROVIDERS TO TREAT CHILD (optional)

By my signature below, I agree that I give Camp personnel permission to transport and accompany my minor child to health care providers when necessary, and I further agree that I give health care providers permission to treat my minor child when admitted in the care of Camp personnel.

Signature of parent/guardian

Date of Signature