



Camp Luther Registrar
Rt. 1, Box 210
Clarksburg, WV 26301

Camper Health Statement 2010

To Be Completed and Signed by Parent

Name _____
Last First MI

Birth date _____ Sex: F M

Camp Program: _____ Juniors (grades 3-5)
_____ Intermediates (grades 6-8)
_____ Seniors (grades 9-12)

Height: _____ Weight: _____

Does your child wear glasses? _____ contacts? _____

Should the nurse/staff be aware of any physical or emotional problems that your child has experienced but is now under control and won't be a problem at camp?

Has your child had any surgery/injury which may affect participation in camp? Please explain. Remember, your child is expected to participate in all the camp program activities.

"If your child is a special needs child please contact the director before continuing. (director@camplutherwv.com)"

Does your child have any of the following (Y/N)

Drug Allergies _____

Describe reaction _____

Other Allergies _____

Describe reaction _____

Diabetes _____ Medication _____

Heart Condition _____ Medication _____

Epilepsy/Convulsions _____ Medication _____

Emotional Problems _____ Medication _____

Ear Problems _____ Medication _____

*Asthma _____ Medication _____

*Bed Wetting _____ Medication _____

*Please describe:

Is your child currently taking any medication other than those already listed? If so, please list medications and reason: _____

My child's immunizations are up to date. Yes No (circle)

Date of last tetanus shot: _____

****Physician's signature is required to validate medical conditions and medications prescribed and to certify that this camper is physically able to participate in all camp activities.**

Physician's signature _____

Emergency Information

Doctor's name: _____ Phone (____) _____

Address _____ City _____ State _____

Name of Primary Insurance Co. _____

Group number or Policy number _____

Please attach a photocopy of your child's health insurance card with this form.

*This camper does **not** have health insurance. _____

List the names of two persons who can assume responsibility for your child in the event of an emergency if you cannot be reached. They can also pick up your child from camp if the child needs to leave before the end of camp!

Name _____ Phone (____) _____

Name _____ Phone (____) _____

If you will be out of town during the week of camp, please provide location and number of where you can be reached.

Location _____ Phone (____) _____

Dates you will be there: _____

I (we) give permission for my child to receive over the counter medication such as Tylenol, ibuprofen, antidiarrheal medication, antibacterial ointment, throat lozenges, eye wash solutions and the like by any of the registered staff members.

_____ **yes** _____ **no** _____ **Parent initials**

I UNDERSTAND THAT IN THE EVENT OF A SERIOUS ILLNESS OR INJURY, I WILL BE NOTIFIED. IF THIS IS NOT POSSIBLE, I HEREBY GIVE PERMISSION FOR EMERGENCY TREATMENT AS RECOMMENDED BY THE APPROPRIATE MEDICAL PERSONNEL.

NAME _____

SIGNATURE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE: home (____) _____ work (____) _____

DATE _____

Please return this completed form with the registration form to:

**Camp Luther Registrar
Rt. 1, Box 210
Clarksburg, WV 26301**

by May 1, 2010