



Crescent Lake Bible Camp
2750 Bible Camp Road
Rhineland, WI 54501



Camper Health Record
(This form needs to be filled out every year.)

The information on this form is not part of the camper acceptance process, but is gathered to assist us in identifying appropriate care. The Health Record must be filled out by parents/guardians of minors or by adults themselves and updated annually. This form **MUST** be mailed to the Camp Office two weeks prior but not more than six (6) months prior to attendance at camp. Campers will not be admitted into the camp program without a completed and signed Health Record.

Camp Session(s): _____

Camper Name: _____ Date of Birth: _____ Age: _____
Last Name First Name M.I.

Parent's/Guardians Name(s): _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Name of Health Insurance*: _____ Policy #: _____

Employer Name: _____ Gender: Female Male

Date of Last Tetanus Booster: _____

Please attach a copy of your Insurance Card to this form.

In case of an emergency, if unable to reach parents, contact:

Name: _____ Relation: _____

Home Phone: _____ Work Phone: _____

Please circle any of the following conditions and/or illnesses that apply to you. In the Comments section (on the next page) please explain to what degree the illness and/or condition currently affects you and if there is any way we can better accommodate your health needs.

Circle if you have ever had:

- | | | |
|------------------------|----------------------------------|-------------------------|
| Chronic Ear Infections | Convulsions / Epileptic Seizures | Emotional Disorders |
| Heart Problems | Hepatitis / Tuberculosis | Serious Health Problems |

Circle if you currently have:

- | | | |
|---------------------------------|-------------------------------|----------------------|
| Arthritis | Asthma / Respiratory Problems | Bedwetting |
| Blood Disorders | Diabetes | Dietary Restrictions |
| Heart Disease (Please explain.) | Physical Disabilities | Sleepwalking |
| Special Needs | Tendency Towards Homesickness | Other: _____ |

Allergic To:

- | | | | | |
|------|----------------|------------|-------------------|-----------------|
| Bees | Food Allergies | Penicillin | Other Medications | Other Allergies |
|------|----------------|------------|-------------------|-----------------|

Please describe reaction(s): _____

Camper Name: _____

List ALL medications currently taken, including psychiatric, vitamins, etc. Please note that all prescription medication MUST have a pharmacy label, including the name of the doctor and be turned into the Health Officer upon arrival at camp. (Medications including epipens, rescue inhalers, etc. will be returned to camper / counselors after being recorded by the Health Officer.) Please use the space below; if more room is required, please write the information in the Comments section or attach a separate sheet.

Purpose	Kind	Frequency	Dosage	Currently Given? (Y/N)

The immunization information is not required. If it is up to date you may simply write up to date on it or fill it out completely if information is known.

Immunizations	Diphtheria	Measles	Mumps	Pertussis	Polio	Tetanus
Date of initial immunizations:						
Date of most recent booster:						

Tuberculin (TB) Test Date _____ Type _____ Results _____
(If skin test is "positive" camper must include a copy of x-ray report)

Have you ever had immunizations for Hepatitis B? (Please circle one.) No Started Series Yes

Special Considerations and Permissions:

If needed, I give permission for the camp nurse to administer: Acetaminophen Initial: _____ Ibuprofen Initial: _____

Please comment on any behavior issues the camp staff should be aware of: _____

Comments:

For youth under 18 years of age: I authorize the Crescent Lake Bible Camp Health Services Representative(s) to administer the medications listed above to my child. In the event I cannot be reached in an emergency, I hereby give permission for the physician selected by the Camp Director or his/her designate, to hospitalize, secure proper treatment for, and to order injection/s, anesthesia, x-rays or surgery for my child named above. I authorize the Camp Director or his/her designate to share the information contained in this form with the camp staff, as needed.

Signature of Parent / Guardian

Date

I certify that this information is true to the best of my knowledge.

Signature

Date