Name ____
Dates of Camp Attendance __________________________

Health History and Examination
Form for Campers and other Guests
of Mt. Cross Lutheran Camp

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Health history must be filled out by parents/guardians of minors or by adults themselves. Update required annually.

Name____ Birth date __________ Age at Camp ______
Last First Middle mm /dd/ yy

Home Address____
Street & Number City State ZIP

Social Security number of participant ______________________________ Gender: ____Male ______ Female

Parent or Guardian ____Phone (______)________________

Home Address ____
(if different from above) Street & Number City State ZIP

Business Address____ Phone(_____)_______________
Street & Number City State ZIP

Other Parent or Guardian or Emergency Contact ____

Home Address____ Phone_____________
Street & Number City State ZIP

Business ____Phone_____________
Street & Number City State ZIP

If not available during emergency, notify ____

Home Address____ Phone___________________
Street & Number City State ZIP

Photocopy of front and back of health insurance card must be attached to this form.
Important – These Boxes must be complete for attendance

Parent/Guardian Authorization: This health history is correct and complete to the best of my knowledge. The person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide routine health care, administer prescribed or over the counter medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child.
In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form maybe photocopied for trips out of camp.
It is recommended that this camper has been examined by a medical personnel in the past 24 months.

Signature of parent/guardian or adult camper/staffer ____

Printed Name ____ Date ________________

I also understand and agree to abide by any restrictions placed on my participation in any camp activities.

Signature of minor or adult camper/staffer ____________________________________ Date _______________

Mt. Cross Health Form
This form is due upon check in at Mt. Cross or you may send in at any time to:
P.O. Box 387
Felton, CA 95018
mtcross@mtcross.org

Name ____
Dates of Camp Attendance ________________________

Health History
The Following information **must be filled in** by the parent/guardian, or adult camper or staff member. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. **Please provide complete information so that the camp can be aware of your needs**.

Allergies List all Known **Medication Allergies** (list) — Describe Reaction and Management of the Reaction

_____________________ ____
_____________________ ____
_____________________ ____

Food Allergies (list)

_____________________ ____
_____________________ ____
_____________________ ____

Other Allergies (list) –include insect stings, hay fever, asthma, animal dander, etc.

_____________________ ____
_____________________ ____
_____________________ ____

Medications being taken
Please List ALL medications (including over the counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescribed drug), the name of the medication, the dosage, and the frequency of administration.

_____ This person takes no medications on a routine basis.

_____ This person takes medications as follows:
Med #1 _______________________ Dosage______________ Specific times each day _______________________
Reason for taking ____

Med #2 _______________________ Dosage _____________ Specific times each day _______________________
Reason for taking ____

Med #3 _______________________ Dosage _____________ Specific times each day _______________________
Reason for taking ____

Any reactions to these medications? ____

What are the effects if missed? ____

Identify any medications taken during the school year that participant does/may not take during the summer:_______
____

Explain any dietary Restrictions (The following restrictions apply to this individual.)

____
____
____

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)

____
____
____

Name ____
Dates of Camp Attendance __________________________

General Questions (Explain yes answers below)
Has/does the participant:

		Yes/No
1.	Had any recent injury, illness or infectious disease?	
2.	Have a chronic or recurring illness/condition?	
3.	Ever been hospitalized?	
4.	Ever had surgery?	
5.	Have frequent headaches?	
6.	Ever had a head injury?	
7.	Ever been knocked unconscious?	
8.	Wear glasses, contacts or protective eyewear?	
9.	Ever had frequent ear infections?	
10.	Ever passed out during or after exercise?	
11.	Ever been dizzy during or after exercise?	
12.	Ever had seizures?	
13.	Ever had chest pain during or after exercise?	
14.	Ever had high blood pressure?	
15.	Ever been diagnosed with a hurt mummer?	

		Yes/No
16.	Ever had back problems?	
17.	Ever had problems with joints?	
18.	Have an orthodontic appliance being brought to camp?	
19.	Have any skin problems (itching, rash, acne)	
20.	Have diabetes?	
21.	Have asthma?	
22.	Had mononucleosis in the past 12 months?	
23.	Had problems with diarrhea/constipation?	
24.	Have problems with sleepwalking/	
25.	If female, have an abnormal menstrual history?	
26.	Have a history of bed wetting?	
27.	Ever had an eating disorder?	
28.	Ever had emotional difficulties for which professional help was sought?	

Please explain any "yes" answers, noting the number of the questions.
____
____
____
____
____

Which of the following
Has the participant had?
○Measles
○ Chicken Pox
○ German measles
○ Mumps
○ Hepatitis A
○ Hepatitis B
○ Hepatitis C

TB Mantoux Test
Date of Last Test_______
Result: ○Positive ○ Negative

Please list whether this person has had these immunizations:

Vaccine:	Date(s)
DTP	____________
TD (tetanus/diphtheria)	____________
Tetanus	____________
Polio	____________
M M R	____________
or measles	____________
or mumps	____________
or Rubella	____________
Haemophilus influenza B	____________
Hepatitis B	____________
Varicella (chicken pox)	____________

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware.
____
____
____
____
____

Name of Family Physician ______________________________ Phone ______________________
Address____

Name of Family dentist/orthodontist _______________________ Phone ______________________
Address____

Name ____
Dates of Camp Attendance ___________________________

Health Care Recommendations by Licensed Medical Personnel
I examined this individual on ___________. (It is recommended that campers have an exam within 24 months of camp attendance, may be filled out by any medical personnel.)

BP _________________ Weight ______________________ Height _____________________

In my opinion, the above applicant: ○ is able to participate in an active camp program
○ is **NOT** able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions:

____
____
____

Recommendations and Restrictions at Camp:

Treatment to be continued at camp

____
____

Medications to be administered at camp (name, dosage, frequency)

____
____

Any medically prescribed meal plan or dietary restrictions:

____
____

Known Allergies:

____
____

Description of any limitation or restriction on camp activities

____
____

Additional information for health care staff at the camp

____
____

Signature of Licensed Medical Personnel ____

Printed Name_________________________________ Title____

Address ____

Phone ____ Date ____

Screening Record for Camp Use Only
Date Screened ____ Time __________am/pm

Updates/Additions to health history noted _____ yes _____ no _____ none required

Current health needs identified ____
____

Observational Notes____
____

Screened by ______________________________