2023 Compass Points
Health History and Physical Examination Form

Please Read
Before Conducting The Physical Exam

Dear Doctor,

This person has registered to take part in a week-long wilderness adventure experience. This experience includes three to five days of backpacking with thirty plus pound packs for five to eight miles per day in remote areas. The program may also include white-water rafting, service work, and/or high and low ropes course elements. These activities will occur at high altitudes, ranging from 8,500 to 14,000 feet. If you would like more information about specific program activities or environments, please contact the Director of Compass Points, at 719-276-5233.

In order for this person to participate in this trip, we require that a health history and physical exam be completed within 12 months of the trip dates. As you complete this exam, we feel that it is important for you to take into consideration how the nature of strenuous activity and high altitude may affect this person and their ability to safely participate.

Please review the attached Health History and complete the Physical Examination Form, and talk with the patient about any concerns that you have for their participation. If you feel that this person is capable of safely participating in the activities listed above, please complete the attached physical exam form.

PLEASE KEEP A COPY OF THIS FORM

Rainbow Trail Lutheran Camp
2023 Health History & Examination Form

Program: Compass Points

CAMP DATES:___________________________

**** This side must be completed by parent/guardian of minors within 6 months prior to arrival at camp. Please notify Rainbow Trail in writing of any changes in this information between the time this form is completed and camp attendance. ****

PLEASE PRINT

Name____ Birthdate_______________ Age______ Sex________
last first initial

Parent or Guardian (or spouse)____ Home Phone: (____)________________
Work Phone: (____)________________

Home Address/City/State/Zip____ Email: _____________________________

If not available in an emergency, notify____________________________________ Relationship_______________________

Address/City/State/Zip____ Phone: (____)________________

Do you carry medical/hospital insurance?__________ If so, please indicate:
Carrier____ Group/policy number____________________________________

Name and phone number of dentist/orthodontist____

Describe any emotional, learning, or psychological concerns and provide information to help us work effectively with this camper:
____

For minor females: Has this person menstruated?___ If not, has she been told about it?___ If yes, is menstrual history normal?___

CHRONIC CONCERNS

____ None
____ Frequent ear infections
____ Heart disease/defect
____ Diabetes
____ Bleeding/clotting disorders
____ Hypertension
____ Asthma/Reactive Airway Disease
____ Seizures/Convulsions
____ Cerebral Palsy
____ Other ____________________________

Provide information on each item checked:
____
____

DISEASES: (Date any that the camper has had)

_____ Chicken pox _____ German Measles
_____ Mumps _____ Hepatitis A
_____ Measles _____ Hepatitis B
_____ Mononucleosis _____ Hepatitis C

Describe any major illness, injury or surgery this camper has had in the past 2 years.__________________________
____

ALLERGIES

____ No known allergies
____ Medications__________________________
____ Insect Stings _______________________
____ Foods ______________________________
____ Other: _________

Describe reaction and management to any listed above:
____
____

MEDICATIONS

****Bring to camp in original container****

List all medication (including vitamins) bringing to camp:

Name of medication ______________________
Reason for taking _______________________
Dosage __________________________________
How often ____________Time of Day____________

Name of medication ______________________
Reason for taking _______________________
Dosage __________________________________
How often ____________Time of Day____________

FOR MORE MEDS, ATTACH ADDITIONAL SHEET

My child has permission to participate in all camp activities, except as noted. I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests and treatment for the health of my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize or secure proper treatment (including surgery, injection, and/or anesthesia) for my child as named above.

Parent/Guardian signature____________________________________ Date________________

Signature of witness____ Date________________

Camper's signature____ Date________________

**** PHYSICIAN MUST COMPLETE THE BACK OF THIS FORM AND SIGN WITHIN 24 MONTHS OF CAMP DATE ***

PLEASE KEEP A COPY OF THIS FORM

COMPASS POINTS -- WEEK OF CAMP:____________________

2023 ** This side to be filled out and signed by a licensed physician or licensed nurse practitioner. 2023
Colorado Law requires that a physical exam must occur within 24 months prior to arrival at camp**

Name of Camper:____ Date of examination: ____________________

Height______ Weight______ Temperature______ Pulse______ Respirations______ Blood Pressure______

This person is under the care of a physician for the following:____

____

Treatment to be continued at camp: ____

____

Medications to be given at camp (include dosages & times): ____

____

Medically prescribed dietary restrictions:

____

Recommendations and restrictions on participation while in camp program:__________________________

____

What special precautions, if any, must be observed for activities at high altitudes? (Altitudes 8,000-14,000 ft)

____

I have examined the above camp applicant, and found him/her to be in satisfactory condition, free from contagious diseases and capable of active participation in an active camp program.

Date examined:_________________________

Physician's signature: ____

Physician's Name (please print): ____

Address: ____
Street and Number City State Zip

Phone: (____)___________________________

For use by camp health care provider (initial for compliance):

________ Health screening performed within 24 hours of camper's arrival.
________ No signs of illness or injury upon arrival at
________ No exposure to communicable disease in past 3 weeks.
________ No additions or corrections to information on health history.
________ Medications given to health care provider.

NOTES:

Please return form to:
Rainbow Trail Lutheran Camp
107 South 9th Street, Ste. B
Canon City, CO 81212

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