Rainbow Trail Lutheran Camp
2024 Health History & Examination Form

FAMILY CAMP WEEK #________

PLEASE PRINT

Head of Household Name____ Birthdate__________ Age_______ Sex_____
Last First

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_______________________________________

Please list each participant for item checked (Example: Mark letter A next to NONE if Participant A does not have any Chronic Concerns)

Name of Participant A _________________________ **Name of Participant D**__________________________
Name of Participant B__________________________ **Name of Participant E**__________________________
Name of Participant C__________________________ **Name of Participant F**__________________________

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:
____

PLEASE KEEP A COPY OF THIS FORM

Rainbow Trail Lutheran Camp **Family Name:___________________**

2024 Family Camp Health Release Form

The participants listed below have 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 our participants, 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 our participants as listed below.

Parent/Guardian Signature____________________________________ Date_____________

Signature of Witness____ Date_____________

*** * * * * * * * * * ***

PLEASE PRINT

Name of Family Camp Participants (List more participants on the back of this form)

____Birthdate___________Age______Sex_____

Last First

____Birthdate___________Age______Sex_____

Last First

____Birthdate___________Age______Sex_____

Last First

____Birthdate___________Age______Sex_____

Last First

____Birthdate___________Age______Sex_____

Last First

____Birthdate___________Age______Sex_____

Last First

PLEASE KEEP A COPY OF THIS FORM