

Rainbow Trail Lutheran Camp 2025 Health History & Examination Form

FAMILY CAMP WEEK # _____

PLEASE PRINT

Head of Household Name _____ Birthdate _____ Age _____ Sex _____
Last First Home Phone: (____) _____

Home Address/City/State/Zip _____ Work Phone: (____) _____
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
2025 Family Camp Health Release Form**

Family Name: _____

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 _____

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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

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