

MOUNT LUTHER MINISTRY TEAM HEALTH FORM

Immunizations

Indicate below that the following are up to date:

DATE VACCINE

_____ DTP	_____ Rubella
_____ Tetanus/Diphtheria (TD)	_____ Hemophilus
_____ Tetanus	_____ influenza B
_____ Polio	_____ Hepatitis B
_____ Measles	_____ TB Mantoux Test
(Hard, red, rubeola)	(Result: _____)

Health Information

Indicate all known allergies (e.g. medication, food, insects, plants), past medical treatment, illnesses or important health history information we may need know as well as any other information we should be aware of, including dietary concerns:

Name _____

Address _____

Home Phone () _____

Date of Birth _____

Parents' Name _____

Cell () _____ Work () _____

Emergency Contact _____

Relationship _____ Phone () _____

Medical Insurance Carrier/Plan Name _____

Guardian Name on Policy _____

Group # _____

Social Security Number _____

Does insurance require MD approval prior to care? _____

Number to call for approval: () _____

I hereby give permission to the medical personnel selected by the camp administration to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatments, including hospitalization, for the above named person. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

Signed, _____

HEALTH EXAM CERTIFICATION BY LICENSED MEDICAL PERSONNEL FOR SUMMER CAMP

I have examined the named participant and in my opinion, he/she is able to participate in an active camp program with the following restrictions/recommendations or treatments at camp:

General Health of Camper: _____ Normal _____ Below Average _____ Sickly.

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

The following **medications** are to be administered at camp:

<u>Drug:</u>	<u>Dosage:</u>	<u>Times Given (indicate breakfast, lunch, supper, bedtime)</u>
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Has or will this individual be taken off any medications for the summer? _____ if yes, please describe and explain why:

Date of last exam _____ BP _____ Weight _____ Height _____

Signature of Licensed Medical Personnel: _____

Name of Family Physician: _____ Phone () _____

Address _____