Camp Omega Health Information Form

Camp Session Name & Date _____

Last Name _____ First Name _____ Gender M F Birthdate _____ Age _____

Name of Parent(s)/Guardian(s) (or Spouse) _____

Home Address _____ City _____ State _____ Zip _____

Phone Numbers: Home _____ Mobile _____ Work _____

Emergency Contact (other than parent/guardian) _____ Relationship _____

Phone Numbers: Home _____ Mobile _____ Work _____

Medical Insurance Co. _____ Policy/Certificate Number _____

Policy Holder's Name _____

Physician _____ Phone _____ Dentist _____ Phone _____

Medications Being Taken: List all medications (including over-the counter) taken routinely. Bring enough in original packaging with complete instructions for entire camp period. Medications will be dispensed according to label instructions.

Medication #1 _____ Dosage _____ When taken each day _____

Medication #2 _____ Dosage _____ When taken each day _____

Medication #3 _____ Dosage _____ When taken each day _____

Are all immunications require for school up to date? Yes ❑ or No ❑ Month & Year of Last Tetanus Shot _____ / _____

Health Information

General Questions (if "yes" explain below)	Yes	No
1. Has food allergies?	❑	❑
2. Must have a gluten free diet?	❑	❑
3. Must have a dairy free diet?	❑	❑
4. Has envionmental allergies?	❑	❑
5. Has a heart condition?	❑	❑
6. Is subject to fainting?	❑	❑
7. Is subject to upset stomach?	❑	❑
8. Is subject to motion sickness?	❑	❑
9. Has a reaction to bee sting?	❑	❑
10. Has a reaction to penicillin?	❑	❑
11. Has a reaction to poison ivy, oak or sumac?	❑	❑
12. Has a reaction to other drugs?	❑	❑
13. Has had a recent injury or illness?	❑	❑

General Questions continued...	Yes	No
14. Has a chronic or recurring illness/condition?	❑	❑
15. Has ever had a seizure?	❑	❑
16. Has had chest pain during or after exercise?	❑	❑
17. Has diabetes?	❑	❑
18. Has asthma?	❑	❑
19. If female, has an abnormal menstrual history?	❑	❑
20. Has a history of bed-wetting?	❑	❑
21. Ever had frequent ear infections?	❑	❑
22. Had mononucleosis in the past 12 months?	❑	❑
23. Has had back problems?	❑	❑
24. Has frequent headaches?	❑	❑
25. Has had high blood pressure?	❑	❑
26. Has activity restrictions or limitations?	❑	❑

Please Attach a Copy of the Participants Immunization Records.

Explainations of activity restrictions or limitations if any: _____

_____

Explainations of past medical treatment if any: _____

_____

Explaination of any physical, mental, or psychological conditions requiring medication, treatment or restrictions if any: _____

_____

Important - This Form Must Be Signed Prior To Participation!

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted.

Authorization for Treatment: I hereby authorize the Camp Omega staff to administer medications and first aid as deamed necessary well as authorize the medical personnel selected by the camp staff to provide routine health care and emergency medical care by medical staff to hospitalize, secure treatment for, order injection, anesthesia, blood transfustions, or surgery, and to release any records necessary for insurance purposes as well as provide or arrange necessary related transportation for the above named participant. This form may be photocopied.

Photo Image Release: As a participant in a Camp Omega event, I give permission and consent to allow photos, videos, and interviews to be taken of the above mentioned individual during the camp session. I further give consent that any such images or interviews may be published in a variety of ways and used to illustrate and promote Camp Omega and the National Lutheran Outdoors Ministry Association.

★ Signature of parent/guardian or adult guest/staff _____ Date _____

For Camp Use -

Updates / Additions to health history noted [ ] Yes [ ] No [ ] None Required

Notes: _____

Release and Application for Exemption from Physical Examination and Immunization Requirements

It is respectfully requested that my child be exempted from the physical examination and all immunization requirements required for attendance at Camp Omega. To the best of my knowledge and belief, s/he is and has been in normal good health and is free from all communicable or contagious diseases.

Should my child manifest any condition where there appears to be reasonable grounds for suspecting the presence of a communicable or contagious diseases, I agree that a physical examination may be performed. Also, I agree that if any such disease is found, he/she will comply with the regular quarantine or isolation procedures of the camp and of the community.

It is further understood that, should an emergency arise, I will be notified immediately. However, in the event that we cannot be located immediately, the authorities of the camp may take such temporary measures as they deem necessary.

I release and forever discharge the camp and each and every one of its officers, directors, partners, shareholders, employees, agents, insurers, affiliates, successors in interest, attorneys, or any other person or persons associated with any or all of them or any variation in the name of any or all of them who might be liable (the “Released Parties”) from all causes of action, suits, claims, demands, or any other damages or costs associated with actions taken by the Released Parties relative to the health, sickness, and treatment of my child

I further understand and acknowledge that I make this release in full accord and satisfaction of and in compromise of any current or future disputed or alleged claims or causes of action relative to the health, sickness, and treatment of my child against the Released Parties.

I represent and acknowledge that I have read and understand this agreement and release and warrant that all statements made herein are true to the best of my knowledge. I further warrant and acknowledge that I am of legal age, legally competent to execute this agreement and release, and accept full responsibility there for.

_____
First & Last Name of Child

_____ _____
Date Signature

_____
Printed Name

_____
Address City State Zip

_____
Contact Phone