LCLC Office Use Only in this Box:

NAME: SPECIAL INFO: PROGRAM: CABIN/TENT:

HEALTH AND EXAMINATION FORM FOR YOUTH & ADULTS

Please be thorough in completing this Health Form. Use only one form per person. All participating campers and adults must have a physician's examination within two years prior to coming to LCLC. Thank you!

LAKE CHAUTAUQUA LUTHERAN CENTER
5013 Route 430, Bemus Point, NY 14712
Phone 716-386-4125 ✚ Fax 716-386-5714

Camper or Adult:

Name *last* _____ *first* _____ Gender____ Age____

Parent/Guardian or Spouse Name_____ Camper/Adult Birthdate____/____/____

Home Phone (_____)_____ Work Phone (_____)_____

Cell Phone (_____)_____ Email _____

Home Address_____

City_____ State_____ Zip_____

Emergency Contact *(other than parent or spouse)*: Name *last* _____ *first* _____

Day Phone (_____)_____ Night Phone (_____)_____

Insurance Information: Insurance Carrier_____ Policy and/or Group #_____

ID # or Social Security # of Policy Holder_____

Immunization History: ***Please Note:*** Immunization dates must be on file at LCLC! Stating that immunizations are current or up to date is not adequate. **New York State mandates that dates be stated**. This information is available from your physician, pediatrician or school nurse.

MMR or Measles (Rubeola) 1st ____/____ 2nd ____/____

Rubella (German or 3-Day Measles) _____/____ Mumps ____/____

Oral Polio (Sabin) *TOPV ____/____ Varicella (Chicken Pox) ____/____

DPT (Diphtheria, Pertussis & Tetanus) Series Completed ____/____

Td or Tetanus Booster (within 10 years) ____/____

Haemophilus Influenza B (HIB)____/____ Hepatitis B_____/____

Tuberculin Test Date (most recent)____/____ Result:_____(not required to attend camp)

Health History: If yes, please check, *give approximate date, and please provide additional information as appropriate in the Special Considerations line below, or on attached sheet.*

☐Diabetes ___/___ ☐Convulsions ___/___ ☐Rheumatic Fever ___/___

☐Fainting ___/___ ☐Hyperactivity ___/___ ☐Infectious Diseases ___/___

☐Seizures ___/___ ☐Serious Injuries ___/___ ☐Stomach Upsets ___/___

☐Surgery ___/___ ☐Frequent Colds ___/___ ☐Emotional Stress ___/___

☐Headaches ___/___ ☐Ear Infections ___/___ ☐Major Orthodontal Surgery___/___

☐Other:_____ ___/___ ☐ Other_____ ___/___

☐ Allergies/Asthma - specify_____

✱ ***Youth & adults with Bee Sting Allergies should bring their own Bee Sting Kit and give it to the Nurse to place in the LCLC Health Center.*** ✱

Is the camper/adult currently involved in **Allergy Desensitization Program**? ☐No ☐Yes

Has the above camper/adult experienced any **sleep disturbance** (bedwetting, sleepwalking, nightmares) on a regular basis? ☐No ☐Yes → Please explain:

_____

Please also complete the next column above the Physician's Section.

Medications: Will the above camper/adult be bringing any over-the-counter or prescription medications to LCLC? ☐No ☐Yes

Please Note: *No prescribed or over-the-counter medications can be administered without a signed prescription from your physician as per NY law. Both* ***over-the-counter and prescription medications*** *to be administered at LCLC must be in the* ***original pharmacy-labeled containers*** *with the patient's name, dosage, times of administration, and any special instructions, one container per medication.*

For Females: Has she menstruated? ☐Yes ☐No

If yes, is her menstrual history normal?_____ ↵ ↳ If no, does she know about it?_____

Other Special Considerations:_____

Authorization and Permission to Provide Necessary Treatment or Emergency Care: The above information is complete and accurate to the best of my knowledge. I hereby give permission to the medical personnel selected by the Executive Director or his appointee to provide routine health care; to administer medications; to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Executive Director or his appointee to secure and administer treatment, including hospitalization, for the person named above. This form may be photocopied for trips out of camp.

Signature *of Parent/Guardian or Adult* _____ *Date*____/____/____

To Be Completed by Licensed Physician or School Nurse:

Examination & Limitations: Date Examined___/___/___ Ht_____ Wt_____lbs. Blood Pressure_____

Limitations or restrictions while at LCLC (camp)_____

Is this person a Vegetarian or following a medically-prescribed meal plan or restriction? ☐ No ☐Yes ➔ *Please attach a written description of the diet.*

Medications & Medical Needs: For medications currently prescribed or over-the-counter ***OR*** specific medical needs, please attach additional information and the required prescription forms.

☐Prescription Form(s) attached ☐Medical Needs Information attached

Please Note: *LCLC requires a current, written prescription from a licensed physician for each medication to be administered at LCLC to any participant.*

By my signature below, I hereby give permission for the following to be administered as needed to the person named above according to label or attached directions:

☐Advil ☐Tylenol ☐Ibuprophen ☐Benedryl ☐Immodium ☐MOM

☐Midol ☐Sudafed ☐Caladryl ☐Robitussin ☐Kaopectate ☐Other:_____

Primary Physician's Signature:

> *Initial if completed by RN or PA* < _____

Print Physician's Name_____Phone (_____)_____

Address_____ City_____ State_____ Zip_____

Date Form Completed____/____/____ By*_____

Address_____ City_____ State_____ Zip_____

* *Full signature & address if completed by a school nurse using information obtained through a school physical.*