



2018 DAY CAMP REGISTRATION & HEALTH HISTORY FORM

NEBRASKA LUTHERAN OUTDOOR MINISTRIES

FOR OFFICE
USE ONLY

Last Name _____

First Name _____

Day Camp Site _____

Dates _____

Child's Name _____ Male Female Birthdate _____
 Grade (2017-2018) _____
 Address _____ Home Phone _____
 City _____ State _____ Zip _____

Parents or Guardians

Name _____ Day Phone () _____ Cell Phone () _____
 Name _____ Day Phone () _____ Cell Phone () _____
 E-mail Address _____

Emergency Contacts/Alternative Persons Authorized for Participant Pick-up

In case of an emergency, we always try to contact the guardian(s) listed above first. If that is not possible, we will also need the names of at least three other contacts (relatives/friends). **Only the adults listed below will be eligible for picking up the participant without a legibly written note signed by the parent/guardian.**

Name _____ Relationship _____ Work Phone () _____ Home Phone () _____
 Name _____ Relationship _____ Work Phone () _____ Home Phone () _____
 Name _____ Relationship _____ Work Phone () _____ Home Phone () _____
 Permission to walk home from Day Camp yes no

Medical History:

Known Allergies (medication, food, other)	Medications being taken, including OTC (list dosage & time taken)	Medical History		
		Y	N	
_____	_____	Recent Injury, illness or disease	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	Frequent Headaches or head injury	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	Glasses/Contacts	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	Chest Pain After Exercise	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	Joint Problems	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	Emotional Difficulties	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	Behavior Concerns	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	Orthodontic Appliances	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	Surgery	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	Other	<input type="checkbox"/>	<input type="checkbox"/>

Please check current immunizations:

- DTaP
- Polio
- Rubella
- Hepatitis B
- Varicella Zoster
- MMR (Measles, mumps, rubella)
- Haemophilus influenza B (HiB)
- TD (tetanus/diphtheria)

Date of most recent tetanus immunization: _____

Please explain any Yes answers _____

Family Doctor _____ Phone () _____ Preferred Hospital _____

List any Chronic/Recurring Illness _____

Medical Insurance Company _____ Policy # _____

Date of Last Medical Exam _____

Additional Information (i.e. physical limitations, restriction on camp activities, disabilities, special diet, etc) _____

Please finish with signed authorizations on the back...

Authorizations:

Permission to administer over-the-counter medications:

I (parent/guardian) give permission for NLOM to provide routine healthcare and administer over-the-counter medications if the health care staff deems necessary. I understand the NLOM Health Care staff will administer medications per instruction in the NLOM Health Care Plan, which is approved by a physician, that dosages will be administered according to the directions on the bottle unless a physician directs otherwise, and that health history forms will be reviewed for allergies and parental recommendations prior to administration of the over-the-counter medications.

Date: _____ Parent/Guardian Signature: _____

Code of Conduct Authorization:

NLOM holds a zero tolerance policy for bullying; If a camper's behavior becomes disruptive to programming or harmful to self or others, NLOM reserves the right to require the disruptive camper to leave camp. Parents/guardians of the camper are responsible for picking up any child asked to be sent home. There will be no full or partial refunds of camp fees under these circumstances.

Date: _____ Parent/Guardian Signature: _____

Permission to participate, authorization for treatment, photo/video release:

This health history is complete 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 give permission to the medical personnel selected by Nebraska Lutheran Outdoor Ministries (NLOM) to order X-rays, routine tests, treatment and necessary transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by NLOM to secure an administer treatment, including hospitalization, for the person as named above. PHOTO/VIDEO RELEASE: I also give NLOM permission to use any photograph/video of my child taken at Day Camp in the future promotions of NLOM.

Date: _____ Parent/Guardian Signature: _____

To help make your child's time at Day Camp successful, it is vital that we are aware of any unique needs or special concerns they may have. Please explain any special learning considerations, family circumstances, relevant experiences, activity restrictions or anything that would help us better prepare for your child's upcoming camp experience. In the event of an emergency or serious illness/injury, parents will be notified by camp staff.