



1531 Edgewood Drive
Milford, IA 51351
712-337-3325
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Lakes Regional Healthcare
Highway 71 South
P.O. Box AB
Spirit Lake, Iowa 51360
712-336-1230

Camper Health History and Authorization Form

Name of Participant _____
Date of Birth _____ Gender Male Female Grade Completed _____

Custodial Parent/Guardian _____
Address, City, State Zip _____
Home Phone _____ Work Phone _____
Cell Phone _____
Employer _____
Employer Address: _____

Other Legal parent/Guardian _____
Address, City, State Zip _____
Home Phone _____ Work Phone _____
Employer _____
Employer Address: _____

Emergency Contact (someone other than parent/guardian who is NOT listed above—
Friend, Neighbor, Grandparent, Aunt/Uncle Etc.)
Name _____ Phone Number _____
Relationship to camper _____

Is Participant covered by Health Insurance? Yes No
If yes, Please attach a copy of the front and back of the card to this form!
If yes, do you have Title XIX Medicaid Medipass
Is this coverage through: Group/ Father Employer Group/ Mother Employer
 Individual Policy Other _____

Policy Number _____ Group Number _____
Insurance Company _____
Address _____
Policy Owner _____
Please enter If your insurance copy requires:
Birthdate of Policy Holder _____

Parent Authorization

I hereby give permission to the medical personnel selected by the camp director to provide routine health care; to administer medications; to order X-rays, routine tests, treatment, to release any records for insurance purposes; and to provide or arrange necessary related transportation for my child. In the event I cannot be reached in any emergency, I hereby give permission to the physicians selected by the camp director to secure and administer treatment, including hospitalization or surgery, for the person named above. The camp will make every effort to notify you before making a doctor's appointment or any emergency room visit for your child while they are in our care. All minor medical needs will be cared for by the on site Health Director without notification of parents. If medical (sickness, injury) care is needed, billings will be sent to the parent/guardian who will be responsible for direct payments to physician, hospital, clinic, etc.

Signature Parent/Guardian _____ Date _____

Diseases or Health Concerns:

- | | | |
|---|--|-------------------------------------|
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Nosebleeds |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Braces |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Behavior | <input type="checkbox"/> Heart |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Seizures | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Sleep Walking | <input type="checkbox"/> Hearing Impaired | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Vision Impaired | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Chronic Illness | <input type="checkbox"/> ADHD |
| <input type="checkbox"/> Stomach upsets | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cramps |
| <input type="checkbox"/> Homesickness | <input type="checkbox"/> Cold/Pneumonia | <input type="checkbox"/> Other |

Allergies (Please List and specify)

Medication and Drug Allergies Please List and Specify _____

******PLEASE SEND MEDICATION TO CAMP IN ORIGINAL CONTAINER WITH PRESCRIPTION LABEL ATTACHED**

Medications:

Name _____	Dosage _____	When Taken _____
Name _____	Dosage _____	When Taken _____
Name _____	Dosage _____	When Taken _____

Physician's

Name: _____ Phone _____

Address _____

Immunizations History: List dates as accurate as possible

Are Participant's immunizations current? Yes NO

DPT Series Booster Tetanus Booster

Polio OPV(Sabin) Booster Tuberculin Test

MMR Other (please list) _____

Any special dietary restrictions or allergies? _____

Any known physical, mental or social difficulties which may affect participation? _____

4/7/2008
