

Lutheran Valley Retreat requires every camper to have a physical within 12 months prior to their camp session; doctor may sign a photocopy of this form, but all signatures must be original and include camper's name.

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_

**Current Medication: Please not, all prescription MUST be prescribed to this individual, within expiration date, and in their original packaging**

Name of Medication	Reason for taking	Dosage	Schedule

**Health History**

Condition	Circle one	If Yes:	Condition	Circle one	If Yes:	Condition	Circle one	If Yes:	Condition	Circle one	If Yes:	Conditions	Circle one	If Yes:
Anxiety or depression	No Yes	Current Past	Recurrent Headaches	No Yes	Current Past	Heart Disease or problems	No Yes	Current Past	Diabetes	No Yes	Current Past	ADD or ADHD	No Yes	Current Past
Epilepsy	No Yes	Current Past	Asthma	No Yes	Current Past	Frequent Colds	No Yes	Current Past	Frequent Ear Infections	No Yes	Current Past	Bed Wetting	No Yes	Current Past
Ear, Nose, or Throat Trouble	No Yes	Current Past	Disease or injury to joints or back	No Yes	Current Past	Stomach or intestine trouble	No Yes	Current Past	Dizzy Spells or Fainting	No Yes	Current Past	Home Sickness	No Yes	Current Past
Eating Disorders	No Yes	Current Past	Comments, other issues, physical limitations and/or list surgeries											

**Allergies/Dietary Needs**

Type of Allergy	Circle	Describe/Specify Allergen	Mild (runny nose, sneezing)	Moderate (Swelling or severe rash)	Severe (System Response/Difficulty breathing)
Food	No Yes				
Medication	No Yes				
Environmental (animal, insect, etc.)	No Yes				
Other	No Yes				
Vegetarian? No Yes Limitations:		Gluten Allergy? No Yes Limitations:		Lactose Intolerant? No Yes Limitations:	

**Immunizations**

Vaccination	Most Recent Date	Vaccination	Most Recent Date	Vaccination	Most Recent Date	Vaccination	Most Recent Date	Vaccination	Most Recent Date
Measles, Mumps, Rubella (MMR)		Hepatitis A		HIB		Chicken Pox (or had the disease)		Influenza	
Diphtheria/Tetanus (DPT)		Hepatitis B		Polio		Other		Other	

I have examined and found camper to be in satisfactory physical condition, free from any contagious disease and capable of active participation in a regular camp program at altitudes of 8,400-9,100 feet above seal level except as follows \_\_\_\_\_

The camper is under the care of a physician for the following condition(s): \_\_\_\_\_

Licensed Physician's Signature \_\_\_\_\_ Date of Examination \_\_\_\_\_

Doctor Name \_\_\_\_\_ Doctor Phone \_\_\_\_\_

Doctor Address \_\_\_\_\_

Doctor City/State/Zip \_\_\_\_\_

**Official Use only (camp staff only to be determined on site): The camper appears to be healthy and free of contagious disease and capable of active participation for all camp activities. Circle one Yes No**