

Lone Tree Ranch Registration/ Health History Form

Information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. **(The top section to be filled in by parents/ guardian of minors or adult campers/ staff members themselves. The bottom section is to be filled out by a licensed Physician for campers under age 18.)**

Date of Camp _____ Date of Birth _____ M/F _____ Age _____ Email _____ Last grade in school _____

Name _____ SS# _____ If you are coming with a group, group name _____

Parent Name _____ Email _____

Home Address _____

City _____ State _____ Zip _____ Phone (_____) _____

For campers under 18:

Father's Occupation _____ Work Phone (_____) _____

Mother's Occupation _____ Work Phone (_____) _____

Guardian's Occupation _____ Work Phone (_____) _____

In case of emergency and neither parent can be reached notify:

Name _____ Phone (_____) _____ Relationship _____

Name of Physician _____ Phone (_____) _____

Chronic or recurring illnesses or medical conditions (stomach upsets, rash, frequent colds, etc)

Check if applicable:

Camp nurse may administer: _____ Tylenol _____ Pepto Bismol _____ Cough Drops to my child.

List any current medication being taken and why they are needed

Operations or serious injuries (dates) _____

List any Swimming or Activity Restrictions _____

Parent's Insurance Company _____

Insurance Company Phone# (_____) _____

****Please attach photocopy of front and back of Insurance Card (helpful in emergencies).**

If you or your child should require medical attention while at one of the Lone Tree Camps for injuries received Or illnesses contracted prior to coming, please send us information necessary to give him/her proper medical service during this time.

In case of emergency, I hereby give permission to the physician selected by the camp director or his staff to hospitalize secure proper treatment for and order injection, anesthesia or surgery for me or my child as named above. I also hereby give my permission for me or my child to participate in all activities, including but not limited to caving, horseback riding, swimming, mountain rappelling, rock wall climbing, waterslide, hiking, rifle range, archery, zip line, camping or traveling, water skiing, and hay rides. Periodically, photographs, videos, or interviews are taken during the camp session. I acknowledge that by participating in this camp session, I give permission and consent for any such photographs, videotapes, or interviews to be used or published to illustrate report, promote, or advertise the camp.

I, therefore, agree to assume, as an explicit condition of my or my child's/ward's participation, any all risks, including, but not limited to these enumerated above. I agree to hold harmless Lone Tree Inc., its staff, the sponsoring church or group from any and all liabilities, claims, demands, and causes of action which may arise due to the participation of myself or my child/ward. **I realize, also, that in the event of illness or injury while attending camp or participating in its activities, medical treatment may be required, I hereby give permission for any such treatment to be rendered, and I agree to hear the cost of such treatment. If any changes occur, I will contact the director.**

FATHER/GUARDIAN'S SIGNATURE

DATE

MOTHER'S/ GUARDIAN'S SIGNATURE

DATE

Health Care Recommendations by Licensed Physician – A copy of this year's **Sports Physical** will be accepted.

I have examined the above camp applicant within the past 24 months: Yes No Date examined _____

In my opinion, the applicant is physically able to participate in an active camp program: Yes No.

List any medically prescribed meal plan or dietary restrictions _____

List any activities to be limited or restricted _____

Current or on-going treatment and/or medication _____

Licensed Physician's Signature

Address _____ Phone(_____) _____

Date of Form Completion _____ Form Completed by (if other than Physician) _____

Health History

(Check if applies. Give approximate dates.)

- Frequent Ear Infections _____
- Heart Defect/Disease _____
- Convulsions/Epilepsy _____
- Diabetes _____
- Bleeding/Clotting Disorders _____
- Hypertension/A.D.D. _____
- Mononucleosis _____

Disease

Vaccination

(Check if applies. Give approximate dates.)

- | | |
|---|-------|
| <input type="checkbox"/> Chicken Pox | _____ |
| <input type="checkbox"/> Measles | _____ |
| <input type="checkbox"/> German Measles | _____ |
| <input type="checkbox"/> Mumps | _____ |
| <input type="checkbox"/> DPT | _____ |
| <input type="checkbox"/> TD | _____ |
| <input type="checkbox"/> Tetanus Test | _____ |
| <input type="checkbox"/> Tuberculin Test | _____ |
| <input type="checkbox"/> Influenza b (HB) | _____ |
| <input type="checkbox"/> H1N1 | _____ |

List any allergies (include food allergies)

Current Treatment for above:
