Luther Heights Bible Camp Adult Health Form

Name: _____ Phone number: _____

Address: _____ Cell phone number: _____

City, State, Zip: _____ Birthdate: _____

Insurance name: _____ Policy Number: _____

Primary care physician: _____ Physician's phone number: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY:

Name: _____ Relationship: _____

Phone number: _____ Cell phone number: _____

LIST ANY CONDITIONS AND RESTRICTIONS YOU MAY HAVE:

Dietary restrictions/diabetes: _____

Allergies: _____

Respiratory or heart condition: _____

Recent operations or illness: _____

Mobility restrictions: _____

Hearing or vision restrictions: _____

Other special restrictions or considerations while at camp: _____

Your current level of exercise: _____ Date of last tetanus shot: _____

Do you require prescription or other medications on a regular basis? _____ If so, please list:

MEDICATION	REASON FOR TAKING

This health history is correct so far as I know, and I understand the risk in engaging in all prescribed camp activities. **Authorization for Treatment:** I hereby give permission to the camp health care personnel to provide routine health care, and to the medical personnel selected by the camp director to order X-rays, routine tests, treatment and necessary transportation for me, and to secure and administer treatment including hospitalization.

Signature:_____Date: _____

I give permission for my photo to be used for Luther Heights Bible Camp publicity purposes: Yes ____ No____

Luther Heights Bible Camp www.lutherheights.org
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