



Participant Name _____

Congregation _____

LWM 2

Living Water Ministries

A Shared Mission of the Lower Michigan Synods, ELCA

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HEALTH HISTORY FORM FOR ALL PARTICIPANTS (Page 1 of 2)

Last Name: _____ First Name: _____

Gender: M F Date of Birth: _____ Age at Camp: _____

Home Address: _____

Custodial Parent/Guardian Name: _____ Phone: _____

Home Address (if different from above): _____

Business Address: _____

Business Phone: _____

Second Parent/Guardian: _____ Phone: _____

Business Address: _____

Business Phone: _____

Person to notify when parent/guardian not available: _____

Relationship: _____ Phone: _____

Address: _____

Insurance Information: Please photocopy the front AND back of your health insurance card and attach it.

Carrier or Plan Name: _____ Group #: _____

THE FOLLOWING BOX MUST BE COMPLETED FOR ATTENDANCE

This health history is correct and complete as far as I know. The person described has permission to engage in all program activities except as noted. I give permission to Living Water Ministries or our Youth Leader to provide routine health care, administer prescribed medications, and seek emergency medical treatment. I agree to the release of any records necessary for insurance purposes. I give permission to Living Water Ministries or our Youth Leader to arrange necessary related transportation for me/my child.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by Living Water Ministries or our Youth Leader, to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips off-site.

I hereby give permission for the Health Officer or our Youth Leader to administer over the counter medications as deemed necessary except as noted on the back of this form.

I understand and agree to abide by any restriction placed on me or my child's participation in program activities.

Signature of Parent/Guardian or Adult Camper/Staff: _____

Printed Name: _____ **Date:** _____

Participant Name _____

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HEALTH HISTORY FORM FOR ALL PARTICIPANTS (Page 2 of 2)

Name of Family Physician: _____ Phone: _____

Address: _____

Name of Dentist: _____ Phone: _____

Address: _____

Does the participant have any activity restrictions? (If yes, please explain): _____

Has the participant had any recent illness, injury, or infectious disease? (If yes, please explain): _____

Does the participant have any behavioral, emotional, or mental health problems about which the camp should be aware? _____

Has the participant had the necessary immunizations? _____ **Please attach photocopy of immunization record**

Allergies: List all known Describe Reaction

Medications

Food

Other Allergies (include insect stings, hay fever, asthma, etc.)

All medications brought by participants must be in the original container and prescriptions must have the participants name on the label from the pharmacy.

Medication	Dose	Frequency	Reason for taking the medication
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SUMMER PROGRAMS ONLY

Medications: Living Water Ministries stocks over the counter medications for upset stomach, diarrhea, colds, allergies, as well as Aspirin, Ibuprophen, Tylenol, and topical ointments and creams. They are administered according to package directions at the discretion of the Health Officer. Are there any over the counter medications that the participant may NOT take?

All medications will be given according to directions on the label.

Please do not send over-the-counter medications unless the participant is taking that medication on a REGULAR basis.

ABUNDANT LIFE PARTICIPANTS ONLY

Please attach a sheet with complete medical history, including surgical history, for this participant.

During check-in, please record when the last bowel movement occurred: _____

Blood Pressure Normal: _____ High Range: _____ Low Range: _____

Pulse Normal: _____ High Range: _____ Low Range: _____ Regular or Irregular

Positive for Hepatitis A, B or C or HIV Yes ___ No ___ If yes, which one: _____