

Participant Name _____

Congregation _____

LWM 3



Living Water Ministries

A Shared Mission of the Lower Michigan Synods, ELCA

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HEALTH EXAMINATION FORM

- This form must be completed by a licensed health care provider.
- A physical dated within 24 months of camp attendance is considered adequate.

Last Name: _____ First Name: _____

Age: _____ Height: _____ Weight: _____ B/P: _____

The participant is under the care of a physician for the following conditions: _____

Treatment to be continued at camp:

Medications to be administered at camp: (name, dose, frequency)

Medically prescribed meal plan or dietary restrictions:

Known allergies, type of reaction, used treatment:

Activity Restrictions:

Additional information about any behavior and physical, mental, and emotional problems for the camp health care staff:

I examined the above named participant on _____ and he/she is is not able to participate in an active camp program.

Signature of Health Care Provider:

Printed Name: _____ Title: _____

Address: _____

Phone: _____ Date: _____

FOR CAMP USE ONLY

Date Screened: _____ Time: _____ Update to health record: Yes No N/A

Meds Received: _____

Current Health Care Needs: _____

Observation Notes: _____

Health Officer Signature: _____