*Home Congregation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**VOYAGEURS LUTHERAN MINISTRY DAY CAMP**

**CAMPER REGISTRATION AND HEALTH HISTORY**

(Required for participation)

Camper Name Male Female

Address Birth Date Grade completed

City, State, Zip Home Phone

Parent/Guardian Cell Phone

Emergency Contact Emergency Phone

Health Insurance Co. Policy No.

IMMUNIZATIONS (Give dates)

DPT Series Polio Immunization

Tetanus Booster Hepatitis B

Haemophilus MMR (Measles, Mumps

influenzae b (Hib) Rubella)

ALLERGIES (Please check and describe reactions in space provided)

Hay Fever Insect Stings Penicillin Poison Ivy

Specific Foods:

Other:

Reactions:

MEDICATIONS (List all medications currently in use)

LIST any illness, chronic condition, or physical consideration the camper has that may affect camp life:

OTHER suggestions that may help us to make your camper’s week more comfortable or enjoyable (fears, anxieties, etc.):

A physical exam is not required unless the camper is under the care of a physician for a medical problem. If this is the case, give physician’s name and pertinent dates and information.

I hereby enroll and give permission for my child to participate in the planned activities of Day Camp. I acknowledge the health of my child to be ready for camp. In the event I cannot be reached in an EMERGENCY, I hereby give my permission to the physician selected by the Day Camp Leader or Congregational Day Camp Coordinator to secure any medical or emergency treatment deemed necessary.

**Parent or Guardian’s Signature**  *(Camper cannot attend unless this is signed)* **Date**