



LAKETRAILS BASE CAMP

session no. _____ dates _____ \

Before June 1st, please mail to:

Laketrails Base Camp
40 N 1st Ave E
Ely, MN 55731

June 1st or later, please mail to:

Laketrails Base Camp
P. O. Box 25
Oak island, MN 56741

CONFIDENTIAL HEALTH FORM FOR CANOE TRIPS

This form is essential for participant's safety. Please fill it out completely.

NAME _____ BIRTH DATE _____ GENDER _____

ADDRESS _____
(No. and Street) (City) (State) (Zip)

PARENT NAME(S) _____ PHONE NO. _____

DOCTOR/CLINIC _____ CLINIC PHONE NO. _____

OTHER PERSON TO NOTIFY IN CASE OF EMERGENCY: _____

EMERGENCY CONTACT PHONE NO.: _____

HEALTH INSURANCE CARRIER _____ POLICY # _____

HEALTH HISTORY

Does your child have a history of (check if "yes")?

- | | |
|--|---|
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Back Problems |
| <input type="checkbox"/> Convulsions/Seizures | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Toothaches |
| <input type="checkbox"/> Kidney/Bladder Problems | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Draining Ears |
| <input type="checkbox"/> Abnormal Blood Pressure | <input type="checkbox"/> Bed Wetting |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Sight or Hearing |
| <input type="checkbox"/> Any not listed here | |

Immunization History

	Last Year Given	Vaccination Dates	Disease Yes/No
Tetanus	_____	Measles _____	_____
Diphtheria	_____	Mumps _____	_____
Polio	_____	Rubella _____	_____
		Pertussis _____	_____

If "yes" to any of the above, please explain: _____

Is your child currently taking any medication? If yes, list medication, dose, frequency & reason for taking: _____

Has your child ever received emotional, behavioral or psychiatric counseling or hospitalization? If so please list date, reason and current status: _____

IS YOUR CHILD ALLERGIC TO ANY OF THE FOLLOWING:

- | | | | |
|-------------------------------------|-----------------------------------|--|--------------------------------|
| <input type="checkbox"/> Insects | <input type="checkbox"/> Clothing | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Other |
| <input type="checkbox"/> Poison Ivy | <input type="checkbox"/> Food | <input type="checkbox"/> Other Medications | |

If "yes" to any of the above, please describe the allergic reaction and how it is treated: _____

Please list any significant injuries within the last six months that could affect the ability to participate in camp activities.

NOTE: Send all medications in original containers and with instructions for use. Camp policy is for Staff to dispense all medications. Please DO NOT SEND OVER THE COUNTER MEDICATIONS to camp. The camp staff will dispense pain relievers, fever reducers, decongestants, antihistamines & antacids as needed from the camp supply.



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PHYSICIAN IS ASKED TO COMPLETE THIS PORTION OF THE FORM

The applicant will be participating in a strenuous camping program including an endurance swimming test and a five day canoe trip that entails several hours of paddling each day, and possibly portaging. It is important that Laketrails be made aware of any health conditions that would hinder his/her ability to participate fully in the Laketrails program.

Camper Name: _____ Session # & Dates: _____

THE NAMED CAMP APPLICANT HAS BEEN EXAMINED WITHIN THE PAST TWO YEARS. YES NO

DATE: _____ HEIGHT _____ WEIGHT _____ BLOOD PRESSURE _____

SIGNIFICANT PAST HISTORY: YES NO . IF YES,
EXPLAIN: _____

CURRENT MEDICAL PROBLEMS: YES NO . IF YES,
EXPLAIN: _____

ANY ABNORMALITIES ON PHYSICAL EXAM OR LAB REPORT: YES NO . IF YES, EXPLAIN: _____

SPECIAL RECOMMENDATIONS FOR CAMPER: YES NO . IF YES,
EXPLAIN: _____

I have examined this person and reviewed his/her health history and conclude that he/she can participate in all camp activities except as noted above.

PHYSICIAN'S SIGNATURE: _____ **DATE** _____

PARENT'S AUTHORIZATION

The above health history is correct as far as I know and the person herein described has permission to engage in wilderness camp activities as presented in the information letter except as noted. **AUTHORIZATION FOR TREATMENT:** I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment and necessary transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, injections, anesthesia, or surgery for my child as named above. I also authorize the camp staff to administer over the counter pain relievers, fever reducers, decongestants, antihistamines & antacids as needed. This completed form may be photocopied to take on the canoe trip.

PARENT'S SIGNATURE: _____
DATE _____

REVIEW OF HEALTH RECORD IN CAMP: SIGNATURE _____

(Camp Health Manager)