HEALTH and EMERGENCY INFORMATION for Adult and Children Family Campers

Complete and return this to our camp office at least two weeks prior to your arrival.

Lutheran Lakeside Camp
23491 170th Street Spirit Lake, Iowa 51360

Questions?
Call Office Manager
712 336 2109

Your Name: ______________________________________
First Name   Middle Initial   Last Name

Date of Birth: ____________________
Month Day Year

Home Address: ______________________________________
Street Address

Phone: (____)____________

City: ________________ State: __________ Zip: ________

1. Date of your most recent tetanus immunization (Month & Year): ______________________________

2. About your nutrition status:
- ☐ I have no food allergies.
- ☐ I am allergic to the foods listed here. (*Check the box if eating this food item triggers anaphylaxis for you.)*
  a. ______________________ ☐ Causes Anaphylaxis b. ______________________ ☐ Causes Anaphylaxis
- ☐ I am a vegetarian of this type (*By indicating that you are vegetarian, we will provide entrees that compliment your indicated vegetarian preference. We rely on you to eat as you've indicated so we do not waste food.)*
  - ☐ Semi-vegetarian (no pork or beef)
  - ☐ Pesco vegetarian (no pork, beef or chicken)
  - ☐ Lacto-ovo vegetarian (no beef, pork, chicken, fish or seafood)
  - ☐ Vegan (no beef, pork, chicken, fish, seafood, eggs or dairy)

3. Do you have a health condition such as a chronic illness or a special circumstance that we should know about because it impacts your ability to participate in this camp program?
   - ☐ No, I am prepared to fully participate.
   - ☐ Yes, as explained: ____

   ____

4. Should the unforeseen occur, who would you like us to notify in an emergency?

Name of Individual: ______________________________ Relationship to you: ________________

Address: ____

Preferred Phone: (______) ____________________ Alternate Phone: (______) ____________________

5. Things you should know about health services while you are at camp:
   a. In case of an emergency, we will call the local ambulance service. It takes at least [**insert time**] for an ambulance to get to camp.
   b. During your stay, Iowa Lakes Regional Health Care Hospital and Family Practice Clinic; M.D., D.O., ARNP, RN is available to help with your emergent health needs.
   c. Our camp **does not** have an AED at camp. Our camp **does not** have portable oxygen at camp.
   d. Adult participants manage their own medications; please bring what you anticipate needing.
   e. There is a **[clinic, hospital, and pharmacy]** available to you in town. These are three miles from camp.

<u>Statement of Agreement</u>

I have read the information both on this page and in what was sent to me as an adult participant for this camp program. I understand my health information will be shared with camp staff on a "need to know" basis and that, as an adult, I retain primary responsibility for managing my health status while at camp. I agree to inform the camp of any changes that might impact my participation.

Your Signature: ______________________________________ Date: ______________
Adult or Parent