CONCORDIA LANGUAGE VILLAGES

Adventure Day Camp *Bemidji Area*
2015 Health History Form

Due: TWO weeks before your child's start date.

Return completed form to:
Adventure Day Camp
Concordia Language Villages
8659 Thorsonveien NE – Bemidji, MN 56601

Villager's Last Name: ______________________

Villager's First Name: ______________________

Birth Date: ____________ Sex: ☐ Male ☐ Female

Language: ____________ Start Date: ____________

Custodial Parent/Adult: ______________________

Parent/Adult Phone
While Child is in Program: ______________________

About healthcare for Adventure Day Camp:

- This program's care is limited to first aid and CPR.
- This program does not dispense routine medication to participants unless arrangement is made prior to arrival by calling the Language Villages' Health Services office at (218) 586–8771.
- Villagers should arrive ready to fully participate in the program. Should your child become unable to participate while with us, we will call so you can take your child home.
- Villagers should bring and use insect repellent (minimum 30% DEET) and sunscreen (minimum 30 SPF) every day.

1. Date (month and year) of your child's most recent tetanus immunization............... ______________________
2. Is this child allergic to any food? .... ☐ YES ☐ NO
   If YES, name the food and the kind of reaction: ______________________ ☐ Intolerance ☐ Anaphylaxis
   ______________________ ☐ Intolerance ☐ Anaphylaxis
3. Does this child react to bee stings with anaphylaxis? .... ☐ YES ☐ NO
4. Does this child have asthma? .... ☐ YES ☐ NO
   If YES, will your child carry a rescue inhaler during the session? .... ☐ YES ☐ NO
   If YES, does your child need staff help to use theat rescue inhaler? .... ☐ YES ☐ NO
   If YES, what triggers your child's asthma? ______________________
5. What else should we know about your child? Please write (below) additional information about your child's health that may impact your child's participation.
   ____
   ____
   ____

Custodial Parent/Guardian authorization to Treat This Child

This information is correct and the child described has permission to participate in all program activities except as noted on this form. I understand that the program limits healthcare to first aid and CPR and that the program staff will call the person listed above in an emergency, when questions about my child's health arise, and/or when my child is unable to continue in the program because of illness or injury. I acknoledge that the program will not distribute routine medication to my child unless I have made prior arrangements. Information on this form may be shared with staff on a need-to-know basis.

Signature of
Custodial Parent/Guardian: ______________________ Date: ____________

Questions? Call the Health Services Office at (218) 586–8771. Thank you!