

ADULT HEALTH FORM 2005

CAMP MOWANA

Mail to: Camp Mowana
2276 Fleming Falls Rd.
Mansfield, Ohio 44903
(419)589-7406
Fax: (419) 589-3096



Name: _____ Phone: () _____

Address: _____

City: _____ State: _____ Zip: _____

Name of Health Insurance: _____ Policy or Group # _____

Date of Birth: _____ SS# _____

(Lutheran Outdoor Ministries provides secondary insurance only.)

In case of emergency, notify:

Name: _____ Phone: () _____

Name: _____ Phone: () _____

Name of Physician: _____ Phone: () _____

Chronic Problems:

- _____ Ear Infections
- _____ Asthma
- _____ Diabetes
- _____ Headaches
- _____ Psychiatric Care
- _____ Seizures
- _____ Heart Disease
- _____ Other-Specify: _____
- _____ None

Allergies

- _____ Food
- _____ Medication
- _____ Penicillin
- _____ _____
- _____ Insect Stings
- _____ Hay Fever
- _____ Other-Specify: _____
- _____ None

Immunization Record:

Tetanus Booster _____
(Date required)

HEALTH HISTORY:

Describe management of chronic problems and/or allergies:

_____ None: _____

Describe past medical treatment, surgeries, hospitalization, injuries, special restrictions or considerations while at camp:

_____ None: _____

List all medications you are currently taking:

_____ None: _____

Dietary Restrictions:

_____ None: _____

Are you a vegetarian?	yes	no
Have you had chicken pox?	yes	no

Please use this space to provide any other information regarding your health:

