

TWIN PEAKS BIBLE CAMP – HEALTH CERTIFICATE

Camp Year _____	Week 1 (Grades 3-4) □ Camper □ Staff	Week 2 (Grades 5-6) □ Camper □ Staff	Week 3 (Grades 7-8) □ Camper □ Staff	Week 4 (High School) □ Camper □ Staff
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Participant Name _____ M / F Date of Birth ____ / ____ / ____ Age ____ Grade ____

Parent/Guardian Name _____ Relation to Participant _____

Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

Place of Employment _____ Email _____

Medical Insurance _____ Policy # _____ Phone (____) _____

Address _____ City _____ State _____ Zip _____

Doctor _____ Phone (____) _____ Dentist _____ Phone (____) _____

IN CASE OF AN EMERGENCY – If I/we cannot be reached, the camp may contact:

Name _____ Relation _____ Phone (____) _____

Address _____ City _____ State _____ Zip _____

In an emergency, I understand that every effort will be made to contact me. In the event I cannot be reached, I hereby give my permission for the physician selected by the Camp Director to secure appropriate treatment for my child, including EMS transport, hospitalization and surgery. I also authorize camp medical staff to provide care to my child as necessary during his/her time as a camper.

→ Parent/Legal Guardian Signature _____ **PARENT SIGNATURE REQUIRED** Date _____

HEALTH HISTORY INFORMATION – All information is private and protected; we appreciate your completion in full so that our health staff can be of the best possible help to our campers and other staff members.

Allergies (drug, food, environmental): _____

Dietary considerations: _____

Medical diagnoses (including, but not limited to, depression, migraines, asthma, blood-borne diseases, etc.): _____

Recent illnesses, operations, or injuries: _____

Ongoing treatments (including use of a joint brace, etc.): _____

List disabilities/limitations on activities: _____

VACCINE RECORDS – Date of most recent tetanus vaccine: _____ Vaccine Record: [] Attached [] Exemption

*COLORADO STATE LAW requires that each camp participant provide a copy of his/her vaccine record or an annual statement of exemption. Please see cover letter for CDPHE-approved forms for vaccine records, which are needed every year you turn in a new Physician's Statement of Health.

*From a licensed pharmacy, properly labeled including name, directions for use and the name of the prescribing practitioner.

CAMPER MEDICATIONS - List all medications/supplements the camper will be take at camp; list by name, dose, route and time to be taken (ex. once a day at bedtime), and potential side effects.

(CAMPER NAME) _____ should take the above medications/supplements as listed while at camp.

He/she **may/may not** (circle one) self-carry and administer his/her *inhaler/s and/or *Epi-Pen. *Only if prescribed by physician.

→ Physician Signature _____ **DOCTOR'S SIGNATURE REQUIRED FOR MEDICATIONS** Date _____

PHYSICIAN'S STATEMENT OF HEALTH: I have examined this camper and find him/her to be in satisfactory physical condition, free from contagious disease and capable of active participation in the regular camping program except as stated above.

→ Physician Signature _____ **DOCTOR'S SIGNATURE FOR STATEMENT OF HEALTH** Date _____

I give permission for _____ to take the above medications while at camp as ordered by my child's physician. I understand I must supply them in compliance with state regulations. I understand the camp uses a Physician-Approved Medication List as needed (including, but not limited to, ibuprofen, acetaminophen, antacids, allergy relief, and triple antibiotic ointment). He/she **may/may not** (circle one) self-carry and administer his/her *inhaler/s and/or *Epi-Pen. He/she **may/may not** (circle one) use sunscreen and insect repellent when appropriate.

PARENT SIGNATURE REQUIRED FOR MEDICATIONS
→ Parent/Legal Guardian Signature _____ Date _____