TWIN PEAKS BIBLE CAMP – HEALTH CERTIFICATE

Camp Year 2021	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

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 mediations 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 (see attached list) as needed. He/she **may/may not** (*circle one*) self-carry and administer his/her *inhaler/s and/or *Epi-Pen.

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

THIS FORM MUST BE FILLED OUT COMPLETELY WITH ALL SIGNATURES IN PLACE FOR US TO ACCEPT YOUR CHILD AS A CAMPER.

COLORADO CERTIFICATE OF IMMUNIZATION

www.coloradoimmunizations.com

COLORADO
Department of Public Health & Environment

This form is to be completed by a health care provider (physician (MD, DO), advanced practice nurse (APN) or delegated physician's assistant (PA)) or school health authority. School required immunizations follow the ACIP schedule. Note: Final doses of DTaP, IPV, MMR and Varicella are required prior to kindergarten entry. Tdap is required at 6th grade entry.

Student Name: _____ **Date of birth:** _____

Parent/guardian: _____

Required vaccines

	Immunization date(s) MM/DD/YY						**Titer date*** MM/DD/YY
Hep B Hepatitis B							
DTaP Diphtheria, Tetanus, Pertussis (pediatric)							
Tdap Tetanus, Diphtheria, Pertussis							
Td Tetanus, Diphtheria							
Hib *Haemophilus influenzae* type b							
IPV/OPV Polio							
PCV Pneumococcal Conjugate							
MMR Measles, Mumps, Rubella							
Measles							
Mumps							
Rubella							
Varicella Chickenpox							

Varicella - date of disease		**Varicella** - positive screen date	

*A positive laboratory titer report must be provided to the school to document immunity.

*The shaded area under "Titer date" indicates that a titer is not acceptable proof of immunity for this vaccine.

Recommended vaccines

	Immunization date(s) MM/DD/YY						
HPV Human Papillomavirus							
Rota Rotavirus							
MCV4/MPSV4 Meningococcal							
Men B Meningococcal							
Hep A Hepatitis A							
Flu Influenza							
Other							

Health care provider signature or stamp: _____ Date: _____

Student is current on required immunizations for age (circle one): Yes No

OR

Immunization record transcribed/reviewed by school health authority:

School health authority signature or stamp: _____ Date: _____

(Optional) I authorize my/my student's school to share my/my student's immunization records with state/local public health agencies and the Colorado Immunization Information System, the state's secure, confidential immunization registry.

Parent/Guardian/Student (emancipated or over 18 yrs old) signature: _____ Date: _____