Camp Year:

TWIN PEAKS BIBLE CAMP STAFF HEALTH HISTORY

□ Wilderness Camp	□ Week 1 (3rd-4th)	□ Week 2 (5th-6th)	□ Week 3 (7th-8th)	□ Week 4 (High School)

PARTICIPANT NAME _____ Male □/ Female □ Date of Birth _____ Age ____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Alt. Phone _____

MEDICAL INSURANCE_____ Policy #_____ Phone _____

Address _____ City _____ State _____ Zip _____

PRIMARY DOCTOR _____ Phone _____

Address _____ City _____ State _____ Zip _____

IN CASE OF AN EMERGENCY the camp may contact and share information about me/my situation with:

Name _____ Relation to Participant _____ Phone _____

HEALTH HISTORY INFORMATION – All information is private and protected; completing this section will help us help you, if necessary!

1. Allergies *(drug, food, environmental)* _____
2. Dietary Considerations _____
3. Medical Diagnoses *(ex. depression, migraines, asthma, blood-borne or cardiovascular disease, etc.)* _____
   _____
4. Recent Illnesses/Operations/Injuries/Ongoing Treatments *(including use of a joint brace, etc.)* _____
   _____
5. Disabilities/Limitations on Activities _____
6. Current Medications _____
7. Date of Most Recent Tetanus Vaccine _____

The above information has been provided to the best of my knowledge; I understand that it will be kept private and protected. I authorize camp medical staff to provide care for me if necessary, and give permission to camp staff to secure emergency medical transport and hospitalization if necessary. I have access to camp medications through the camp health care provider.

VOLUNTEER STAFF SIGNATURE (over 18) _____ Date _____

MINOR STAFF VOLUNTEER (Under 18 Years of Age)

Parent/Guardian Name _____ Relation to Participant _____

Home Phone _____ Cell Phone _____ Alt. Phone _____

Parent Consents & Signature

- ✓ I authorize camp medical staff to provide care to my child as necessary during his/her time as a staff volunteer. **Initials** _____
- ✓ I authorize the camp medical staff to administer over-the-counter medications from the Physician-Approved List as needed to my child.
  Do not give to my child:_____ **Initials** _____
- ✓ In an emergency, I understand that every effort will be made to contact me and/or the emergency contact listed above. In the event that I cannot be reached, I hereby give my permission for the Camp Director, camp medical staff, and/or camp physician to secure appropriate treatment for my child, including emergency medical services transport, hospitalization and surgery. **Initials** _____

I understand and agree to the above authorizations, permissions, and consents. The information on this page is accurate to the best of my knowledge.

PARENT/GUARDIAN SIGNATURE PARENT/GUARDIAN SIGNATURE REQUIRED Date _____