

# TRFC Children / Youth Information and Medical History Form

**PLEASE RETURN THIS FORM AS SOON AS POSSIBLE**

Camper First Name \_\_\_\_\_ Camper Last Name \_\_\_\_\_ Camp Session \_\_\_\_\_

Camp Dates \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Weight \_\_\_\_\_ Gender: Male \_\_\_\_\_ Female \_\_\_\_\_

Custodial Parent(s) / Guardian(s) \_\_\_\_\_

Primary Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone - Mom (\_\_\_\_) \_\_\_\_\_ Cell Phone - Dad (\_\_\_\_) \_\_\_\_\_

Email \_\_\_\_\_ Work Phone - Mom (\_\_\_\_) \_\_\_\_\_ Work Phone - Dad (\_\_\_\_) \_\_\_\_\_

I would like a free camp t-shirt (circle size) Child: L XL Adult: S M L XL XXL

**TRANSPORTATION:** I would like my child to return home from camp with \_\_\_\_\_  
(please list name of parent, friend, or church)

Parents must give written permission to Twin Rocks Friends Camp if they desire anyone other than the above to transport camper's home from camp.

**NEEDS ASSESSMENT:** Twin Rocks desires to help meet each child's physical, social and spiritual needs. Please describe below how we might be of assistance in meeting your child's unique needs. Attach additional paperwork if needed.

**HEALTH HISTORY:** Camper health and medical information needs to be made known to the camp. Camp personnel will hold this information in confidence. If insufficient space is provided, please attach additional paperwork if needed.

**DATE OF LAST MEDICAL EXAM:** \_\_\_\_\_ **Given by:** \_\_\_\_\_

**ALLERGIES:** List all known allergies. Describe reaction and management of the reaction.

Medication Allergies: \_\_\_\_\_

Food Allergies or Special Diet Needs: \_\_\_\_\_

Other Allergies: (include insect stings, hay fever, asthma, animal dander, etc.) \_\_\_\_\_

Has your child experienced any of these? Please circle number and explain all that apply.

- |  |  |
|--|--|
| 1. Recent injury, illness or infectious disease? | 11. ADHD / ADD?                            |
| 2. Chronic or recurring illness?                 | 12. Heart disease?                         |
| 3. Ever been hospitalized?                       | 13. If female, abnormal menstrual history? |
| 4. Ever had surgery?                             | 14. Eating disorder?                       |
| 5. Frequent headaches?                           | 15. Depression?                            |
| 6. Head injury?                                  | 16. Sleep problems?                        |
| 7. Frequent ear infections?                      | 17. Psychiatric treatment?                 |
| 8. Ever passed out during or after exercise?     | 18. Bed wetting (recently)?                |
| 9. Had seizures?                                 | 19. Respiratory problems?                  |
| 10. Diabetes?                                    | 20. Other?                                 |

Please explain any "yes" answers, noting the number of the question. \_\_\_\_\_

Are there any other medical conditions or restrictions we should be aware of that would limit your child's ability to participate in camp activities? \_\_\_\_\_

## HEALTH INSURANCE:

Do you carry family health insurance? Yes \_\_\_ No \_\_\_ Carrier \_\_\_\_\_ Group ID# \_\_\_\_\_

Family Doctor or Health Care Facility: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Family Dentist/Orthodontist: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

*-More Questions on Reverse Side*

**IMMUNIZATIONS: Dates:**

Tetanus Booster (required) #1 \_\_\_\_\_ #2 \_\_\_\_\_

DPT #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_ #4 \_\_\_\_\_ #5 \_\_\_\_\_

Polio OPV / IPV #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_ #4 \_\_\_\_\_ #5 \_\_\_\_\_

Measles MMR #1 \_\_\_\_\_ #2 \_\_\_\_\_

TB Test (if foreign born or exposure to tuberculosis) #1 \_\_\_\_\_

Hepatitis B #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_

Chicken Pox #1 \_\_\_\_\_ #2 \_\_\_\_\_

Hepatitis A #1 \_\_\_\_\_ #2 \_\_\_\_\_ Menactra \_\_\_\_\_ #1 \_\_\_\_\_

**MEDICATIONS:** List ALL medications including over-the-counter or non-prescription drugs taken routinely. Bring enough to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage and the frequency of administration. Please do not take your child off regular medicines while at camp. Attach additional paperwork if needed for more medications. Identify any medications taken during the school year that participant does/may not take during the summer.

Medication #1 \_\_\_\_\_ Dosage \_\_\_\_\_

Specific times to be taken each day \_\_\_\_\_ Reason for taking \_\_\_\_\_

Medication #2 \_\_\_\_\_ Dosage \_\_\_\_\_

Specific times to be taken each day \_\_\_\_\_ Reason for taking \_\_\_\_\_

**ASTHMATICS:** I give my child permission to carry an inhaler to self administer for asthma related incidents. \_\_\_\_\_ (parent initial) **OR**  
 I prefer the camp nurse keep my camper's inhaler and to help my camper determine when it is needed (recommended for Girls and Boys Camp). \_\_\_\_\_ (parent initial)

**EMERGENCY AUTHORIZATION AND LIABILITY RELEASE:** This health history is correct so far as I know, and the person described above has permission to engage in all camp activities except as noted. I have familiarized myself with the camp program and events and understand that all activities are completely voluntary. I recognize the inherent risk of injury in camp activities and particularly, but not limited to: swimming, boating, archery, Extreme Swing and some beach activities. I understand that Twin Rocks Friends Camp has taken extensive safety measures, including the certification of its staff in first aid, CPR and water safety as well as making every effort to aid the safety of all camp participants. However, I also recognize that Twin Rocks Friends Camp cannot insure or guarantee that the participants, equipment, grounds and/or activities will be free of accidents or injuries. I am aware and have instructed my child in the importance of knowing and abiding by the camp's rules and regulations and do release Twin Rocks Friends Camp from all liability for any injury to the camper. I understand that transportation to and from camp (and any liability thereof) is the responsibility of the camper, and not that of Twin Rocks Friends Camp.

I give permission to the camp nurse/physician to (1) administer the camper's routine medications, 'as needed' medications, and over-the-counter medications for minor illnesses or discomfort; (2) provide appropriate first aid for minor injuries; and (3) seek further treatment from local physician or hospital if condition warrants. In the event I cannot be reached in an emergency, I give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for the camper named above. This completed form may be photocopied by the camp to have a second set available for transportation records and for Twin Rocks Friends Camp's office.

I give permission for Twin Rocks Friends Camp to use any photo, video, or interview taken at camp to be used to illustrate, report, promote and advertise Twin Rocks Friends Camp.

**Date** \_\_\_\_\_ **Signature of Parent/Guardian** \_\_\_\_\_

**EMERGENCY CONTACT:** In case we cannot be reached in an emergency, please notify the following individual:  
 (1) Name \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_ Daytime Phone (\_\_\_\_) \_\_\_\_\_  
 Cell Phone (\_\_\_\_) \_\_\_\_\_ Relationship \_\_\_\_\_  
 (2) Name \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_ Daytime Phone (\_\_\_\_) \_\_\_\_\_  
 Cell Phone (\_\_\_\_) \_\_\_\_\_ Relationship \_\_\_\_\_