

# Twinlow After School Camp 2011-2012

## Participant Registration & Health History Form

### Camper Information

Name \_\_\_\_\_ Birth date \_\_\_\_\_ Age \_\_\_\_\_  
Preferred Name \_\_\_\_\_ Gender \_\_\_\_\_ Grade \_\_\_\_\_  
Mailing Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone (home) (\_\_\_\_) \_\_\_\_\_ Home e-mail address \_\_\_\_\_  
Parent 1 Name \_\_\_\_\_ Parent 2 Name \_\_\_\_\_  
Parent 1 Work \_\_\_\_\_ Parent 2 Work \_\_\_\_\_  
Parent 1 Cell \_\_\_\_\_ Parent 2 Cell \_\_\_\_\_  
Child lives with (circle one):    Parent 1    Parent 2    Both    Guardian  
Emergency Contact \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ Relationship \_\_\_\_\_

**Cost per week: \$50.00 per child**

Additional adults authorized to pick up child:

**Check the days your child will usually attend:**

- Monday
- Tuesday
- Wednesday
- Thursday
- Friday
- Early Release Days

Adults NOT authorized to pick up my child:

### Authorization/Permission:

Is your child allowed to participate in winter tubing/sledding at camp?  Yes  No  
Is your child allowed to participate in field trips during the day?  Yes  No  
Is your child allowed to participate in swimming & boating activities at camp?  Yes  No

### Parent/Guardian Authorization

I, the undersigned parent/guardian, give permission for the above named camper to participate in the camp indicated above. I recognize and acknowledge that camping activity can involve certain hazards, including, but not limited to, illness, injury and accidents, and release Twinlow Camp and The United Methodist Church from liability. I give permission for:

- Standard medical treatment according to Camp Physician Standing Orders.
- Emergency medical treatment in the case that I cannot be contacted
- Administering physician prescribed medications
- Release of information for insurance purposes
- Transportation for scheduled off-site events
- Photos to be used in future publicity

The following health history is accurate and complete as far as I know.

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

**Current Health Conditions** Please describe any current health conditions requiring medications, treatment, or special restrictions or considerations while at camp. \_\_\_\_\_

**Past Medical Conditions/Health History** Please describe past medical treatment, (i.e., surgeries, heart conditions, fainting, seizures, etc.) or other medical concerns. \_\_\_\_\_

**Allergies** List all known allergies including those involving medication, food, insect, asthma, hay fever and other allergies. Please describe reaction and management.

ALLERGY

REACTION AND MANAGEMENT

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medications**

\_\_\_ NO Medications on a routine basis      \_\_\_ My Child will be bringing medication to camp.

Please list ALL medications (including over-the-counter or non prescription drugs) that will be used at camp. Keep medications 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 be advised that all medications must be turned in to the Camp Health Care Provider prior to camper arrival.

**Immunizations:** Please attach a copy of your child's immunization record.

**Special Needs/Restrictions:**

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary) and provide any information that will enable us to create a healthy, helpful environment for the camper. Please include: recent injuries or illnesses, medical conditions requiring treatment, behavioral/learning challenges and suggested disciplines, emotional needs/concerns, hearing impairments, visual impairments, special routines. (Attach additional page, if necessary.) Include dietary restrictions other than allergies mentioned above.

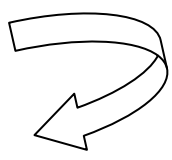
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Insurance Information**

Insurance Carrier or Plan Name \_\_\_\_\_ Group # \_\_\_\_\_  
Name of Insured \_\_\_\_\_ Relationship \_\_\_\_\_  
Insurance ID or Policy # \_\_\_\_\_  
Name of Family Physician \_\_\_\_\_ Phone ( ) \_\_\_\_\_

*The above information must be filled in by the parent/guardian. The intent of this information is to provide camp health care personnel the background to provide appropriate care. KEEP A COPY OF THE COMPLETED FORM FOR YOUR RECORDS. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp.*

**Mailing Information**



Make checks payable to:  
**Twinlow Camp**

Mail completed forms with first weeks payment to:  
**Twinlow Camp**  
**22787 N. Twinlow Rd.**  
**Rathdrum, ID 83858**