



# MEDICAL & DIETARY INFORMATION

Participant Name \_\_\_\_\_ Date \_\_\_\_\_

List any special dietary needs \_\_\_\_\_

**Allergies**—Please list all known allergies including those involving medication, food, insect, asthma, hay fever and other allergies. Describe reaction and management:

Allergy	Reaction and Management
_____	_____
_____	_____

**Medications**—Please list all medications taken routinely:

Name _____	Dosage _____	Time Taken _____
Name _____	Dosage _____	Time Taken _____
Name _____	Dosage _____	Time Taken _____

*Please bring medications in original packaging/bottle that identifies the prescribing physician, the name of the medication, the dosage, and the frequency of administration.*

**Current Health Conditions**—Please describe any current health conditions requiring medications, treatment, or special restrictions or considerations: \_\_\_\_\_

**Past Medical History**—Please describe past medical treatment, (surgeries, heart conditions, fainting, seizures, etc.) or other medical concerns: \_\_\_\_\_

Date of last Physical \_\_\_\_\_ Date of last Tetanus \_\_\_\_\_

Are immunizations current? \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Family Doctor/Healthcare Provider \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Carrier or Plan Name \_\_\_\_\_ Group # \_\_\_\_\_

Name of Insured \_\_\_\_\_ Policy # \_\_\_\_\_

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 activities can involve certain hazards, including, but not limited to, illness, injury, and accidents and release 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 above health history is accurate and complete as far as I know.

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

Signature of Adult Participant \_\_\_\_\_ Date \_\_\_\_\_

Mail your Medical Form with your Registration Form to:  
Twinlow Camp & Retreat Center, 22787 N. Twinlow Rd, Rathdrum, ID 83858