Camp Session attending _____ Cabin assignment _____

CAMP TRINITY 2024

P. O. Drawer 380
Salter Path, NC 28575
FAX: (252) 247-3290 EMAIL: nreynolds@trinityctr.org

Important! This box must be completed by a parent or guardian for a camper to attend camp and sent to us 30 days prior to the session's start date. It must be signed, dated, and have the insurance information.

This health history is correct to my knowledge and the person described herein has permission to engage in all prescribed camp activities, except as noted.

Authorization for Treatment: *In the event I cannot be reached in an Emergency, I hereby give permission to the Physician, selected by the Camp Director, to secure proper treatment for: transport, hospitalize, and order injection, X-ray, routine tests, anesthesia, or surgery for the person named above. I also give permission to the Camp Nurse to dispense any prescribed medication and/or over the counter medication as needed to the person named below.*

_____ _____

Signature of parent/guardian or adult camper:_____**Date:** _____

Family medical/hospital insurance (please attach copy of insurance card):

Carrier_____**Policy/Group#**_____

CAMPER'S NAME _____ Birthdate _____ Sex_____ Age_____
Parent/Guardian_____
Home Address_____City_____ State____ Zipcode_____
Phone: Day (____)_____ Night (____)_____ Mother Cell(____)_____Father Cell (____)_____

Vacation address(*if applicable*)_____City _____ State ____ Zipcode _____
Phone: (____)_____ Dates: _____

Emergency Contact:
Name_____ Relationship_____ Phone: (____)_____

If this person is not available in an Emergency, please notify:
Name/relationship_____ Phone: (____)_____

Primary Care:

Name of camper's Physician and Phone _____
Name of camper's Dentist and Phone _____

Health History: (Indicate with approximate dates)

Ear Infections_____ Asthma_____ Convulsions_____ Diabetes_____ Hearth defects/disease_____
Mononucleosis_____

Diseases:

Measles_____ German Measles_____ Chicken Pox_____ Mumps_____ Other_____

Allergies:

Hay Fever_____ Ivy Poisoning_____ Insect bites/stings_____ Penicillin_____ Sulfa_____
Other (specify) _____

Other:

Disabilities, chronic or recurring illness: _____
Operations or serious injuries (include dates): _____
Mental or physical problems: _____
Dietary modifications: _____
Problems with bed-wetting/comments: _____

Has this person presently or previously undergone psychiatric and/or substance abuse treatment of any type?
Explain: _____

For Females Only:

Has this person menstruated? _____ If no, has she been told about it? _____
Is her history normal? _____ Special Considerations _____

Parents comments and suggestions: (activities to be encouraged/restricted, special concerns and explanations)

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Camper:_____

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MEDICAL EXAMINATION: TO BE COMPLETED BY A LICENSED PHYSICIAN

PLEASE NOTE: A health history/examination form must be completed and sent into the camp office **EACH YEAR** by a parent or guardian **30 days** before admission to a camp session. A physician's examination for some other purpose within the past year is acceptable **if** the information requested on that form is the same as for this request. Examination is necessary in case of illness or accident and to determine fitness to engage in all camp activities.

IMMUNIZATION HISTORY: (Dates of basic immunizations/most recent booster doses OR attach records to form)

DTP/DTaP _____ Booster _____ MMR_____ _____
Td/TDAP _____ Booster _____ Tuberculin Test_____
Polio Series_____ Booster _____ Varicella (disease)_____ vaccine _____
Hep B Series _____ Hep A_____ Menactra _____

GENERAL APPRAISAL:

Height _____ Weight_____ BP _____
Eyes_____ Glasses/contacts_____ Nose _____
Teeth_____ Braces_____ Throat _____
Ears _____ Heart _____
Speech_____ Hearing_____ Lungs _____

RECOMMENDATIONS AND RESTRICTIONS WHILE AT CAMP:

The applicant is under the care of a physician for the following condition(s):_____
_____
Current treatment to be continued at camp_____
_____
Specific medications: prescription and OTC, to be administered at camp_____
_____
Swimming _____
Strenuous activity (describe)_____
Dietary restrictions_____
Allergies(food, drugs, plant, insect)_____
Additional health information_____
_____

Licensed Physician's Signature
I have examined the person described herein and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in camp activities, except as noted above.

_____ _____ _____
Signature of Examining Physician Date (Please print or type name)

(____)_____-_____ _____ _____ _____
Telephone City State Zip

Date form completed_____*By_____

*Initial if completed by nurse or physician's assistant

A note to parents: Please notify the camp nurse **at check - in** if the camper has been exposed to or exhibits any symptoms of a communicable disease during the **three weeks** prior to camp attendance. Do not bring a sick child to camp. We reserve the right to send campers home who are sick on arrival.