Please complete this form and return it to Twin Rocks Friends Camp as soon as possible. Completed forms can be emailed to: friendscamp@twinrocks.org, faxed to the camp at 503-355-8341, or returned by mail at Twin Rocks Friends Camp, P.O. Box 6, Rockaway Beach, OR 97136.

TRFC Children/Youth Information and Medical History Form

PLEASE RETURN THIS FORM AS SOON AS POSSIBLE

Camper First _____ Camper Last _____ Camp (circle one): JJam Day Kids Tween Surfside

Camp Dates _____ Birthdate _____ Age _____ Weight _____Gender: Male ☐ Female ☐

Custodial Parent(s)/Guardian(s) _____Grade in Fall 2022_____

Mailing Address _____ City _____ State ____ Zip _____

Phone(s) for Custodial Parent/Guardian _____ _____Relationship to camper _____

Phone(s) for Custodial Parent/Guardian _____ _____Relationship to camper _____

Email _____ Camp buddy/roommate preference(s)_____

T-shirt size (if provided at this camp) Child: ☐ S ☐ M ☐L ☐ XL Adult: ☐ S ☐ M ☐ L ☐ XL ☐ XXL

TRANSPORTATION: Parent/Guardians please list all persons (INCLUDING YOURSELF(VES) authorized to pick up your child 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 check number and explain all that apply.

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

Camper Name_____

IMMUNIZATIONS Dates: (OK to include copy of immunization record.)

Tetanus Booster: _____ (mm/yyyy REQUIRED) Hepatitis B: _____
DPT: _____ Chicken Pox: _____
Polio OPV / IPV: _____ Hepatitis A: _____
Measles MMR: _____ Menactra: _____
TB Test (if foreign born or exposure to tuberculosis): _____

Immunization Comments:

☐ Exempt from immunizations: _____ (Parent Signature)

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 elementary age campers)._____ (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, zip line, Extreme Swing and some beach activities. I recognize that injury to person may include, but is not limited to the following: sickness; exposure to infectious/communicable disease (including COVID-19); bodily, emotional, and personal injury; death; and property and financial damage.

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 or appropriately trained and certified staff 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.

My typed name below is the same as my signature and indicates that I attest to all the information contained in this form

Date _____ Signature of Parent/Guardian _____

NON-PARENT EMERGENCY CONTACTS: ***In case parents cannot be reached*** in an emergency, notify the following:

(1) Name _____ Relationship to camper _____
Home Phone _____ Daytime Phone _____ Cell Phone _____

(2) Name _____ Relationship to camper _____
Home Phone _____ Daytime Phone _____ Cell Phone _____