MEDICAL RELEASE FORM (All Campers and Sponsors)

In the event of an accident or special health needs, it will be necessary for us to have the requested information. Please make certain that you have provided thorough and accurate medical information. It is recommended that you attach a photocopy of your family medical insurance card.

Name: _____ Birth Date: _____/_____/_____ Age: ___ Sex: (M/F) _____
First Middle Last Mo. Day Year

Church: _____ City: _____ Dates at TPCC: _____/____/____ to _____/____/____

Person to Notify in **Event of Emergency:** _____ Relationship to You: _____

Phone Number of Contact Person: Daytime (_____)_____ Evening (_____)_____ Other (_____)_____

If unable to reach above person: Notify _____ Relationship to You: _____

Phone Number of Contact Person: Daytime (_____)_____ Evening (_____)_____ Other (_____)_____

Family Physician: _____ Phone: (_____) _____

Medical Insurance Co.: _____ Plan or Group #: _____

Insured ID or Member #: _____ Ins. Co. Phone #: (_____)_____

MEDICAL INFORMATION

Significant Allergies (specify)

- ❑ Food: _____
- ❑ Insect Sting: _____
- ❑ Medicine/Drug: _____
- ❑ Plant/Pollen: _____
- ❑ Other: _____

Special Diet: _____

Recent Surgery? _____

Date of last Tetanus Shot? _____ Immunizations Current? _____

Diseases, Chronic or Recurring Illness: (Check all that apply, explain)

- ❑ Asthma: _____
- ❑ Bleeding Disorder: _____
- ❑ Joint or Back Problems: _____
- ❑ Diabetes: _____
- ❑ Epilepsy: _____
- ❑ Heart Condition: _____
- ❑ Seizures: _____
- ❑ Stomach Condition: _____
- ❑ Emotional: _____

HEALTH CARE AND CAMP PERMISSION— <u>INITIAL & SIGN THE STATEMENTS BELOW.</u>

____ I give permission for first aid techniques and simple health care to be administered as the need arises. I understand in the event of any serious injury or illness on my part the camp officials reserve the right to seek professional medical attention including but not limited to consultation with medical director, EMS transportation, and hospitalization.

____ I give permission for myself or my child/ward, in consultation with the Camp Health Supervisor and/or the medical director's standing orders, to take the following medications as indicated by checking below:

___acetaminophen (i.e. Tylenol)	___Ibuprofen (i.e. Advil)	___decongestant (i.e. Sudafed)
___antihistamine (i.e. Benadryl, Claritin)	___antihistamine cream	___antibacterial ointment
___antacid tablet (i.e. Tums)	___additional medications as indicated/prescribed by the HLC Medical Director	

I hereby attest that all information listed on this Medical Form is complete and accurate to the best of my knowledge that I or my child/ward am/is in acceptable heath, physical ability, and emotionally ready to fully participate in camp or retreat activities. I grant my permission to participate in all activities associated with the enrolled event with the exceptions of those that are noted.

I, _____ being the legal guardian of _____(if applicable)give my permission to Trinity Pines Conference Center's management, medical staff, and/or the group director to provide medical treatment that may be deemed necessary to insure the well-being of myself/the named camper. I do hereby release and forever discharge all from any and all claims, demands, actions or cause of action arising out of damage or injury while participating in Trinity Pines sponsored activities.

X _____ ____/____/____ (_____) _____
Signature Date Phone Number