

_____	Date
_____	Camp Number

**TIMBER-LEE CHRISTIAN CENTER HEALTH, CONSENT, AND RELEASE FORM**

NOTE TO THE PARENTI/GUARDIAN/GUEST: Timber-lee wants the camp experience to be a safe and healthy one. However, in the event of an accident or illness, it is important that we have the following information:

1. Medical history
2. Medical insurance information

**PERSONAL INFORMATION**

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_  
Last First MI

Parent or Guardian (or spouse) \_\_\_\_\_

Home Address \_\_\_\_\_ Phone \_\_\_\_\_  
Street and Number City State/Province Zip/Postal Area/Number

Business Address \_\_\_\_\_ Phone \_\_\_\_\_  
Street and Number City State/Province Zip/Postal Area/Number

Second Parent or Guardian Emergency Contact \_\_\_\_\_

Home Address \_\_\_\_\_ Phone \_\_\_\_\_  
Street and Number City State/Province Zip/Postal Area/Number

Business Address \_\_\_\_\_ Phone \_\_\_\_\_  
Street and Number City State/Province Zip/Postal Area/Number

If not available in an emergency, notify: Name \_\_\_\_\_

Home Address \_\_\_\_\_ Phone \_\_\_\_\_  
Street and Number City State/Province Zip/Postal Area/Number

**HEALTH HISTORY INFORMATION**

Health History (Give approximate dates)	Diseases	Allergies (Date not needed)
_____ Frequent Ear Infections	_____ Chicken Pox	_____ Hay Fever
_____ Heart Defect/Disease	_____ Measles	_____ Ivy Poisoning, etc.
_____ Diabetes	_____ German Measles	_____ Insect Stings
_____ Bleeding/Clotting Disorder	_____ Mumps	_____ Penicillin
_____ Hypertension	<b>Immunizations</b>	_____ Other Drugs
_____ Mononucleosis	_____ Tetanus (last date)	_____ Asthma
_____ Convulsions	_____ Other (Specify) _____	_____ Other (Specify) _____

Operations or serious injuries (Dates) \_\_\_\_\_

Chronic or recurring illness or medical condition \_\_\_\_\_

Current medications (Send with instructions in original container) \_\_\_\_\_

Other illnesses \_\_\_\_\_

Name of family physician \_\_\_\_\_ Phone \_\_\_\_\_

Name of dentist/orthodontist \_\_\_\_\_ Phone \_\_\_\_\_

Date of last health examination by a doctor or nurse \_\_\_\_\_

**Insurance Information**

My insurance company \_\_\_\_\_ Policy Number \_\_\_\_\_

Insurance company address \_\_\_\_\_

Any treatment to be continued at camp \_\_\_\_\_

Any medically prescribed meal plan or dietary restrictions (please notify camp staff two weeks prior to arrival) \_\_\_\_\_

Activities to be discouraged or limited \_\_\_\_\_

Additional health information for camp personnel \_\_\_\_\_

Please complete second page