

CAMP TRINITY 2025

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: _____		
<u>Emergency Contact:</u>			
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.