Idaho Mission Project Health & Release Form

1. Bring with you to camp (or)
2. Send to Twinlow Camp
   22787 N. Twinlow Rd. – Rathdrum, ID 83858 (or)
3. scan and email to: office@twinlowcamp.org

Name ____

Birth date_______/______/_______

Address

Street/PO Box:

City: State: Zip:

Best Phone( )___________________ Email: _____________________________________

Dates of Camp: _____________________ Church or Group Name: ____________________________

ALLERGIES: List all known allergies, including those involving medication, food, insect, asthma, hay fever and other allergies. Please describe reaction and management.

ALLERGY	REACTION AND MANAGEMENT
_______________________________________	______________________________________
______________________________________	______________________________________
______________________________________	______________________________________

Family Doctor or Healthcare Facility _________________________ Phone (___)________________
Emergency Contact _______________________________________ Phone (___)________________
Secondary Contact ____________________________________ Phone (___)________________

Insurance Carrier or Plan Name

____

Group #

____

Name of Insured ____
Relationship _____________________
Insurance ID or Policy #

____

MEDICATIONS Please list ALL medications (including over-the-counter or non prescription drugs) taken routinely. Keep medications 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 be advised that your group leader will be responsible for health care and Twinlow will have health staff that can assist.

____ NO Medications on a routine basis

MED. #1 ______________________________________ DOSAGE

SPECIFIC TIMES TAKEN EACH DAY_______________

REASON FOR TAKING

____

MED. #2 ______________________________________ DOSAGE

SPECIFIC TIMES TAKEN EACH DAY_______________

REASON FOR TAKING

____

MED. #3 ______________________________________ DOSAGE

SPECIFIC TIMES TAKEN EACH DAY_______________

REASON FOR TAKING

____

CURRENT HEALTH CONDITIONS Please describe any current health conditions requiring medications, treatment, or special restrictions or considerations while at camp.

____

____

PAST MEDICAL HISTORY Please describe past medical treatment, (i.e., surgeries, heart conditions, fainting, seizures, etc.) or other medical concerns.

____

____

Are you current on all immunizations? _________ Yes _________ No
Date of last physical ______________________ Date of last Tetanus______________________________
Do you have a health condition (e.g. allergies, chronic conditions) or special circumstances which may affect program participation, special housing need, or anything we ought to know prior to emergency treatment?
Yes ____ No _____
If yes, please explain:

____

____

FOR PERSONS AGE 17 YEARS OR YOUNGER I, the undersigned parent/guardian, give permission for the above named to participate in Idaho Misison Project week long camp and mission trip experience. I understand that program activities will involve transportation off site. I authorize use of photos for future publicity. I realize that the church/youth/group/adult leader are primarily responsible for the health and well-being of my child, I also hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. In signing this form, I hereby certify that the above information is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted. I agree to the release of any records necessary for insurance purposes. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization. This completed form may be photocopied for trips out of camp.

Signature of parent/guardian ________________________________
Date _____________________________

Address/City/State/Zip____
Best Phone (_________)____
Other Phone (_________)____

FOR PERSONS AGE 18 YEARS OR OLDER --In signing this form, I hereby certify that this information is correct and complete as far as I know. I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment, including ordering x-rays or routine tests. In case of medical emergency, I understand that every effort will be made to contact the above named Emergency contact person. In the event they cannot be reached, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization. I agree to the release of any records necessary for insurance purposes. I authorize use of photos for future publicity.

Signature of Adult Leader____
Date ________________________________