

STAFF HEALTH FORM FOR CAMP TAPAWINGO

(Please print)

Date: ___ / ___ / ___

First Name: _____ Last Name: _____ M F

Date of Birth: ___ / ___ / _____ Age _____ Entering grade (if still in school) _____

Address: _____

City: _____ State: _____ Zip+4: _____ - _____

Home phone: _____ - _____ - _____ Work phone: _____ - _____ - _____ Cell: _____ - _____ - _____

Church Name: _____ Phone: _____ - _____ - _____

If you are under the age of 18, please provide the following information:

Parent/Guardian Name: _____

Address: _____

City: _____ State: _____ Zip+4: _____ - _____

Home phone: _____ - _____ - _____ Work phone: _____ - _____ - _____ Cell: _____ - _____ - _____

Should I experience a health care emergency, after critical care has been provided, please contact one of the following.

Name: _____ Relationship to you: _____

Home phone: _____ - _____ - _____ Work phone: _____ - _____ - _____ Cell: _____ - _____ - _____

Address: _____

City: _____ State: _____ Zip+4: _____ - _____

Name: _____ Relationship to you: _____

Home phone: _____ - _____ - _____ Work phone: _____ - _____ - _____ Cell: _____ - _____ - _____

Address: _____

City: _____ State: _____ Zip+4: _____ - _____

Health and General History:

Tetanus Booster: ___ / ___ / _____

Please note any activity restrictions: _____

Please identify any medical condition or medical history that would require special attention:

If the camper will be taking medications during camp, please indicate name of drug and dosage. All prescription and over-the-counter medications must be in the original container and turned into camp nurse at time of check-in.

EMERGENCY MEDICATIONS: If you are under the age of 18, please have parent/ guardian sign if applicable.

My child has permission to carry his/her own emergency medication (rescue inhaler, glucagon, epinephrine) while at camp:

Parent/ guardian signature: _____ date: _____

Allergies (note reaction and treatment):

Doctor: _____ Phone: (____) ____ - _____
Dentist: _____ Phone: (____) ____ - _____
Insurance Co: _____ Phone: (____) ____ - _____
ID#: _____

Is there any other medical, dental, or psychological condition or concern we should know about?

Applicant's Statement:

I/we hereby authorize any health care provider(s) selected by the manager of Tapawingo, to act as my/our agent to administer first aid, or to hospitalize, secure proper treatment for, order injection, anesthesia, or surgery for myself, as named above. This authorization will be effective from the time my camp service officially begins to the time it officially ends, both as determined by the manager of Tapawingo. I/we acknowledge our financial responsibility for any health care services provided, and agree to pay for all services rendered to the above named staff person, as a result of any illness or injury sustained during camp. I/we also agree to hold harmless Tapawingo, and its staff, from any health care liability as a result of participation in the camping program, or health treatment. . I further agree that my child can receive over-the-counter remedies (Tylenol, Ibuprofen, Antihistamine, etc.) I give permission for photos/ video of my child to be used by North American Baptist Northwest Association and by Camp Tapawingo in camp related resources and publications. I/we have read this paragraph and agree with its content. I/we also understand that this is a legally binding document.

Staff Applicant's Signature: _____ Date: ____/____/____

Witness or Parent/Legal Guardian: _____ Date: ____/____/____

Please initial here if you DO NOT want your child to receive over-the-counter medications if needed while at camp.
