



Name \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

**HEALTH / MEDICAL FORM**  
(Please print clearly)

ONE for EACH PERSON

Is there any reason you or your child cannot engage in recreational activities such as running, swimming, competitive games and hiking?  No  Yes, because

\_\_\_\_\_

Please include the necessary information, if applicable. The person listed above has the following:

- Asthma  Asthma Medication
- Diabetes  Diabetes Medication
- Epilepsy  Epilepsy Medication
- Other Health Condition  Medication
- Other medical problem or disability: \_\_\_\_\_

\_\_\_\_\_

**If you have checked any of the boxes above, be sure to fill out the Medications Form completely.**

- Allergies:
- Penicillin  Poison Oak  Bee Sting
  - Other \_\_\_\_\_

**Do you have food or drink allergies?**  Yes  No

**If yes, fill out the Special Diet Needs form.**

Everyone at camp must have had a tetanus shot within 10 yrs.

Date of Last Tetanus Shot: \_\_\_\_\_

Operations in last year?  Yes  No

(If Yes, please describe) \_\_\_\_\_

Permission to Swim?  Yes  No

Sleepwalk?  Yes  No

IN CASE OF ILLNESS OR INJURY, after every reasonable effort has been made to contact parent or guardian of child 18 years or younger, or in the event that an adult camper is unable to authorize treatment, I authorize the camp nurse to sign in my place for necessary treatment by a local physician and/or for hospital care.

\_\_\_\_\_ Parent or guardian name (print)

\_\_\_\_\_ Parent or guardian name (signed)

Phone number: (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**IN AN EMERGENCY, CONTACT FIRST:**  
**\*\*Star the number(s) below that we may use to contact this person during camp.**

Please Print

\_\_\_\_\_ FIRST NAME \_\_\_\_\_ LAST NAME

Phone # Home (\_\_\_\_) \_\_\_\_\_

Work (\_\_\_\_) \_\_\_\_\_

Cell (\_\_\_\_) \_\_\_\_\_

Relationship to camper: \_\_\_\_\_

**IN AN EMERGENCY, CONTACT SECOND:**  
**\*\*Star the number(s) below that we may use to contact this person during camp.**

Please Print

\_\_\_\_\_ FIRST NAME \_\_\_\_\_ LAST NAME

Phone # Home (\_\_\_\_) \_\_\_\_\_

Work (\_\_\_\_) \_\_\_\_\_

Cell (\_\_\_\_) \_\_\_\_\_

Relationship to camper: \_\_\_\_\_

Physician's name: \_\_\_\_\_

Physician's phone: (\_\_\_\_) \_\_\_\_\_

Dentist's name: \_\_\_\_\_

Dentist's phone:(\_\_\_\_) \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_

ID Number and Group: \_\_\_\_\_

**Insurance must be valid in the State of Oregon. If not, you are personally responsible for any medical expenses necessary for camper.**



Date \_\_\_\_\_ Camper \_\_\_\_\_ Age \_\_\_\_\_

Staff \_\_\_\_\_

**THIS PAGE MUST BE FILLED OUT AND SIGNED BY THE CAMPER (OR PARENTS, IF THE CAMPER IS UNDER 18), OR STAFF MEMBER**

**Medical Release—Authorization for care, and Liability Agreement**

I, the camper or parent or guardian for the camper (under 18), or the staff member, have had a physical examination in the past year and am able to attend NWCCD. I accept full responsibility for transportation, and/or any related costs for medical services, should the need for any service occur during the week of NWCCD. I authorize the camp nurse, camp physician, or camp director to transfer the above person to an advanced level of care facility for treatment, including a hospital, a clinic, and/or emergency transport vehicle. I authorize release of: Medical health history information, Health care provider, and Insurance information. I have medical insurance that is valid in the State of Oregon. I authorize the camp nurse to dispense medications as indicated on the NWCCD Medications Form. I have listed every medication on the NWCCD Medications Form.

Please print your name \_\_\_\_\_  
(Parent, Guardian or camper age 18 or above)

Your signature \_\_\_\_\_  
(Parent, Guardian or camper age 18 or above)

Date \_\_\_\_\_

**This is the second of 2 pages for this document. Both must be filled out.**

NORTHWEST CHRISTIAN CAMP FOR THE DEAF is designed for Deaf and Hard-of-Hearing people. If an individual requires personal care assistance for “Activities of Daily Living” that individual must provide the personal care assistant at their own expense. Furthermore, it is required that said personal care assistant provide full assistance for the camp attendee during NWCCD camp week. The personal care assistant must complete all NWCCD registration forms and all camp fees must be paid.