Please fill out both pages completely and return them with full payment to Camp Indianola, PO Box 1150 Indianola, WA 98342. Packing list and other details can be found at www.campindianola.org.

When: **October 20 - 22**
Where: **Camp Indianola**
How Much: **$80**

Questions? Please call the camp office at (360) 207-1519

Camper Name:_____ Age:_____ Grade:_____

Gender:_____ Street Address:_____

City: _____ Zip:_____

Parent/Guardian Phone: (_____)_____ Secondary Phone: (_____)_____

Email:_____ Local Church:_____

☐ Check this box if you would like to receive information by email about summer programs at Camp Indianola.

Camper Name:	Birth date:

Does camper have any known allergies:	Yes	No	Is the camper current on all immunizations needed for school?	Yes	No
SEVERE allergies to:			Do they carry an Epipen?	Yes	No
Medication Allergies:					
Food Allergies :			Dietary Restrictions:		
Other Allergies:					

Date of last tetanus shot/TDAP(month and year needed):	Blood type:

HEALTH HISTORY-within the last 3 years. Check any that apply:							
Alcohol/drug addiction		Bed-wetting		Headaches		Self-mutilation	
Anxiety		Diabetes	Type 1 / Type 2	Heart disease		Sleepwalking	
Asthma		Depression		Infections, ear infections		Sore throats-frequent	
Attention deficient/ hyperactivity		Eating disorders		Menstrual problems		Tobacco Usage	
Back pain/strain		Epilepsy or Seizures		Nightmares		Other:	
Pertinent Past Medical treatment/surgeries:							

Does the camper have a health issue (e.g. allergies, chronic conditions) or special circumstances which may affect program participation, special housing needs, or anything we need to know prior to emergency treatment?	No	Yes:_____ (if so, please describe on separate page)

MEDICATIONS Keep all medications (Prescriptions and Over-the-Counter) IN THE ORIGINAL CONTAINERS that identify: prescribing physician, medication name, dosage and frequency. All medications for age-level campers must be checked in to camp health care provider at registration.

Name:	Dosage:	Time to give:	Reason:
Name:	Dosage:	Time to give:	Reason:
Name:	Dosage:	Time to give:	Reason:
Name:	Dosage:	Time to give:	Reason:

Identify medications that camper has recently stopped taking:

List any additional medications on an additional page.

CONSENT AND MEDICAL RELEASE

FAMILY MEDICAL INSURANCE	Yes	No
Name of Insured:		
Carrier:	Group #:	
Policy#:		
Name of Family Physician:		
Phone: ( )		

- I, the undersigned parent/guardian, give permission for the above named camper to participate in the camp indicated on this form. I recognize and acknowledge that camping activities can involve certain hazards, including, but not limited to illness, injury, and accidents, and release The United Methodist Church from liability. My child has permission to partake in all supervised camp activities unless limitations are noted.
- I authorize the PNW Camp Health Provider to administer the above listed medications to my child/dependent during camp. I have given the Health Care Provider dosage and administrative instructions.
- I hereby give permission to the camp to provide routine health care, dispense medications, and seek emergency medical treatment.
- I have either appropriate insurance or agree to pay for all the medical service costs as may be incurred by my camper/self.
- In an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the above named person.

- I agree to the release of any records necessary for insurance purposes.
- I give permission to the camp to arrange necessary related transportation for my child.
- This completed health form may be photocopied for trips out of camp.
- I give permission for photos/videos to be used in future publicity.
- I give permission Camper's name or e-mail address to be included in address list.

	Parent/Guardian/Self Signature:	Date: