

MEDICAL STATEMENT FOR CAMP WILLOW SPRINGS

All information requested below must be filled out by parent/guardian and on file before a camper can be admitted to and participate in the camp program.

1. Camp Dates: April 17-19, 2026

2. Group Name: Trinity Methodist Church

3. Camper's Name: _____

Address: _____

Home Phone: _____ Office Phone: _____

4. Camper's age: _____ Birth Date: _____

5. Medical History:

a. General Health: _____

b. Limitations: _____

c. Special Diet: _____

Reason: _____

(Attach sample menus or special food list)

d. Medications needed at camp: _____

Reason: _____

e. Allergies: _____

Medications used to treat allergies: _____

f. Ability to participate in full camp program: _____

g. Immunizations (give current dates):

1. Tetanus _____ 2. Polio _____

3. MMR _____ 4. DPT Series _____

6. Doctor's name: _____

Address: _____

Phone: _____

7. Parental Consent:

I hereby authorize the staff at Camp Willow Springs to act as an agent for me according to their best judgment in any emergency situation requiring medical attention for the above named Camper. I hereby expressly agree to waive, release and discharge Camp Willow Springs, its officers, directors, shareholders, agents and its Staff from any and all claims, demands, causes of actions, damages, obligations, costs, expenses arise out of or related to any injury or illnesses incurred by the above named Camper while at camp. I acknowledge that all the medical information given is accurate and up to date; I agree to promptly notify CWS if any change occurs in my child's living at camp. I acknowledge and agree that I have read all of the terms herein and agree I am executing this waiver on behalf of myself and on behalf of the Camper named above. I execute this voluntarily and with full knowledge of its significance.

Parent/Guardian Signature: _____ Date: _____

Emergency Contact Person(s): _____

Emergency Contact Phone Number(s): _____