TEACHER APPLICATION T.R.C.C. CAMP 2008

Junior Week You Are Willing To Teach
(July 6 - July 10 or July 13 - July 17)

JUNIOR WEEK 1:
JUNIOR WEEK 2:

Name:	
	Last First Initial
Address:	
Phone:	
Email:	
Home Congregation:	
Teaching Experience:	

Tidal River Christian Camp
http://www.trcc.info
Haddam, Connecticut
Youth Camp Health Examination Record

Expiration Date ....

To Be Completed By Parent or Guardian

Name ______________________________ Sex ____ Age ____ Birth Date ____________
(last) (first)

Address ______________________________ Phone ______________
(street) (town) (state) (zip)

In Emergency Notify ______________________________ Relationship ______________

Address ______________________________ Phone ______________

Camper Medical History (check) | Allergies | Chronic/Recurring Illness

Chickenpox ________ Measles ________ Hay Fever ________ Insect Sting ________ Earaches ______ Throat Problems __

German Measles ________ Mumps ________ Asthma ________ Drugs (specify) ________ Sinus ______ Infections ______

Whooping Cough ________ Other ________ Ivy, Oak, Etc. ________ Foods (specify) ________ Heart ______ Stomach ______

Details of above ______________________________ Epilepsy ______ Rheumatic Fever __

______________________________ Diabetes ______ Menstrual ______

Medications Being Taken (name and explain) ______________________________ Problems ______

____

Operations, Injuries, Special restrictions (explain and give dates) ______________________________

____

Immunization	Date	Booster
Diphtheria	________	________
Tetanus	________	________
Pertussis	________	________
Polio	________	________
Measles	________	________
Mumps	________	________
Rubella	________	________
Other	________	________

Parent or Guardian Me Authorization (required for all persons under age 18) This health history is correct so far as I know, and the person named above has permission to participate in all camp activities except as noted by me or the examining physician. If I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and order injection, anesthesia for surgery for the person named above.

Signature ______________________ Date ______________

Physical Examination: To be completed By A Licensed Physician: (Code: 1=Satisfactory 2=Not Satisfactory 0=Not Examined)

Height ________ Weight ________ B.P. ________ Skin ________ Nose ________

Eyes ________ Glasses ________ Contacts ________ Required ________ Condition ________

Ears ________ Hearing Right ________ Left ________

Throat ________ Teeth ________ Heart ________ Lungs ________ Skeletal ________

Abdomen ________ Genitalia ________ Hernia ________ Extremities ________

Test: Urinalysis Glucose % ________ Albumin % ________ Tuberculin Testing (type) ________

If indicated, Blood Count ______________________________

Restrictions, Limitations (including diet) ______________________________

____

Medications ______________________________

Recommendations ______________________________

The above named person is in satisfactory condition and may engage in all camp activities except as noted.

Date of Exam ________ Examining Physician ______________________________

Telephone ________ Print Physician's Name ______________________________

State Licensed In ________ Lic. # ________ Address ______________________________

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