

# TRIPPER DAVE'S JUNIOR ADVENTURE COMPANY

## MEDICAL FORM

Name: \_\_\_\_\_  
FIRST MIDDLE LAST

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Weight: \_\_\_\_\_ kg  
YEAR MONTH DAY

Address: \_\_\_\_\_ Unit: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Health Card: \_\_\_\_\_ Version Code: \_\_\_\_\_

### PARENT 1 / PRIMARY CONTACT

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

### PARENT 2 / SECONDARY CONTACT

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

### EMERGENCY CONTACT 1

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_

### EMERGENCY CONTACT 2

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_

Current medical problems or conditions:

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Past serious illnesses or injuries or surgeries:

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Medications, doses, and when they should be taken:

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Dietary restrictions:

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Allergies including seasonal, environmental, insect bites/stings, food, and drug:

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Describe the nature of the allergic reactions and how you manage them:

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Has the camper ever had anaphylaxis?  yes  no to what: \_\_\_\_\_

Does the camper have an Epi-Pen?  yes  no

Has the camper ever had asthma?  yes  no severe?

Does the camper ever wet the bed?  yes  no

Does the camper have nightmares?  yes  no

Are all immunizations up to date?  yes  no never immunized?

In what year was the camper's last tetanus booster vaccine? \_\_\_\_\_

Child's doctor: \_\_\_\_\_ Office phone: \_\_\_\_\_

This represents an accurate assessment of my child's health and physical well-being. In the event of injury or illness, beyond informed consent obtained directly from an emancipated minor, I authorize any staff member of Tripper Dave's Junior Adventure Company to provide appropriate first-aid care for my child, including the administration of non-emergency medications as needed. In the event of a medical emergency wherein efforts to reach the child's custodial guardians are unsuccessful, then I authorize the tripping staff to seek and approve necessary emergency medical treatment at the nearest hospital.

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Name of Parent / Guardian

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Signature of Parent / Guardian

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Date