

HEALTH AND MEDICAL INFORMATION



Every Participant Must Have This Form on File.

Participant Name _____ Social Security Number _____

Address _____
Street City State Zip

Phone Number _____ Date of Birth _____

Health Insurance

Health insurance information must be provided. The participant's parents or guardians are responsible for paying any costs not covered by insurance.

Policy Holder Name _____

Address _____
Street City State Zip

Relationship to Participant _____

Insurance Provider _____ Effective Date _____

Address _____
Street City State Zip

Phone Number _____

Group # _____ Policy # _____ Contract # _____

Employee # _____

Medical Information

Primary Care Physician _____ Phone Number _____

Address _____
Street City State Zip

Does the participant have a medical history involving any of the following?

	Yes	No		Yes	No
Allergies	___	___	Heart Disease	___	___
Convulsions	___	___	Phobias or Fears	___	___
Diabetes	___	___	Past Injuries/Illnesses	___	___
Disabilities	___	___	Past Operations	___	___
Epilepsy/Seizure Disorder	___	___	Other	___	___

If you answered "yes" to any of the above conditions, please explain in detail. Use a separate page if necessary.

Provide instructions for handling side effects and emergency procedures for the above conditions:

Note: If participants take medications, they should bring an adequate supply and at all times carry a list of those medications in case of an emergency.

Emergency Contacts

Person(s) to be contacted in case of an emergency:

Name _____ Relationship _____

Address _____

Day Phone _____ Evening _____ Cell _____

Name _____ Relationship _____

Address _____

Day Phone _____ Evening _____ Cell _____

Name _____ Relationship _____

Address _____

Day Phone _____ Evening _____ Cell _____

I hereby authorize the release of any medical information that might be needed in connection with the payment for medical services.

I request that payments from my medical insurance be made directly to the provider(s) of medical services. I understand that I am financially responsible for the payment of all medical services rendered to the camp participant.

Participant Signature _____ Date _____

Parent/Guardian Signature _____ Date _____