Medical Information

Name_____
Last First

Participant with: (Church/Organization attending)

_____

Birthdate _____ Sex _____ Age _____

Parents/Guardian_____

Address_____
City State Zip

Email Address_____

Work/Cell Phone_____

Physician's Name _____ Phone (___) _____

Health Insurance Co. & Address_____

Policy No._____

Health Problems/Special Needs_____
Drug/Food Allergies_____

Polio Vaccine Current Y / N Last Tetanus Shot _____

Regular Medication_____
Activity Restriction_____ _

PARENTS: Please read, sign, and date the following: Our insurance coverage is a secondary carrier. Our campers' insurance begins where yours terminates. It is only valid when your policy has been extended to its limits. In the event that you have no personal or organizational policy, our policy will provide you with complete coverage within its limits subject to policy provisions. Please provide us with the name of your health insurance carrier and your policy number in the event of a hospital visit.

"IN CASE OF A MEDICAL EMERGENCY, I hereby give permission to the physician selected by the Camp Director to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for my child, as named above."

Signature _____ Date _____

***Important**: Please notify the camp if child has a communicable disease. If applicable, please photocopy*

insurance card and submit with this sheet.