MEDICAL FORM

THIS IS FOR YOUR SAFETY

Please fill out this form as thorough as you can. We will not disclose any information unless it's an emergency. All information will be destroyed after camp.

Name____
____
Address____
____
____

Phone numbers you think we should have:
____
____

Date of Birth:______________________________________

SSN/ID#:______________________________________

Blood Type:______________________________________
Prior Transfusion Reaction (describe):__________________
____
____

Contact Lenses? ☐ Dentures? ☐

Diabetic? ☐ Epileptic? ☐

Known allergies to medications? (list)__________________
____
____
____

Medications taking now? (list):__________________________
____
____

Other medical conditions? (list):________________________
____

Surgeries or Hospitalisations? (year, what done, location):
____
____

Insurance Co. (leave blank if no insurance):______________
____

Group number:______________________________________
Policy number:______________________________________

Primary Physician and/or Medical Treatment Facility:
Physicians Name:______________________________________
____

Name of Clinic/Hospital:______________________________
____

Address____
____
____

Phone:____

Next of Kin or person to be notified in an Emergency:

Name____
____
Address____
____
____

Phone:____
Relation:____

Other person(s) to be notified in an Emergency:
Name____
____
Address____
____
____

Phone:____
Relation:____

Please write on the back of the form if you need more space.