PINE SPRINGS CAMP

CONFIDENTIAL HEALTH INFORMATION FORM

Last Name: _____ First Name: _____ Birthdate: _____/_____/_____

Address: _____
Street City State Zip

Phone: (_____) _____-_____ Parent/Guardian Cell: (_____) _____-_____

Emergency Contact: _____Phone: (_____) _____-_____

Date of last Tetanus shot: _____

Allergic reactions? Bee stings: _____ Penicillin: _____Other drugs: _____

Foods: _____ Please Specify: _____

Able to take Tylenol? _____ Currently on any medication? Yes No

If yes please specify: _____

Medication _____ Dosage _____ x Daily _____ Specific time's _____

Prescribing Physician _____Phone:(_____)_____-_____

Medication _____ Dosage _____ x Daily _____ Specific time's _____

Prescribing Physician _____Phone: (_____) _____-_____

Any physical impairment that would limit your physical activity? _____

_____

Hospital Insurance Carrier: _____Policy #: _____

Group #: _____

In the event of any medical condition or EMERGENCY, I hereby give permission to the Physician selected by the Camp Director to hospitalize, secure proper treatment and/or order injection, anesthesia, or surgery.

Signature:

_____Date: _____/____/_____