

## MEDICAL INFORMATION

Name \_\_\_\_\_  
Last First

Participant with: (Church/Organization attending)

\_\_\_\_\_

Birth date \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_

Parents/Guardian \_\_\_\_\_

Address \_\_\_\_\_

Emergency No./Work Phone \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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 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.