

## MEDICAL and EMERGENCY INFORMATION

NAME: \_\_\_\_\_ SEX: M  F  AGE: \_\_\_\_\_

STREET: \_\_\_\_\_ DOB: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PARENT/GUARDIAN NAME: \_\_\_\_\_

ADDRESS (if different): \_\_\_\_\_

TELEPHONE: \_\_\_\_\_ (H) \_\_\_\_\_ (O)

\_\_\_\_\_ (C) \_\_\_\_\_ (other)

EMERGENCY CONTACT: \_\_\_\_\_ RELATION: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_ (H) \_\_\_\_\_ (O)

**Camper's Medical Information** : Please check those that apply (Use reverse side for details, if needed)

Chronic Ailments	Allergies
<input type="checkbox"/> Asthma or Other Respiratory Problems	<input type="checkbox"/> Medication
<input type="checkbox"/> Diabetes or Hypoglycemia	<input type="checkbox"/> Bee Stings/Insect Bites
<input type="checkbox"/> Hemophilia or Other Bleeding Problems	<input type="checkbox"/> Foods
<input type="checkbox"/> Circulatory or Heart Problems	<input type="checkbox"/> Others, if significant
<input type="checkbox"/> Epilepsy	

Date of last Tetanus Shot: \_\_\_\_\_ Camper wears glasses/contacts? Yes  No

Current Medications if any: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Health Insurance: \_\_\_\_\_ Number: \_\_\_\_\_

I, the undersigned, as parent/guardian, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis or procedure rendered under the general or specific supervision of any member of the medical staff or of a dentist licensed under the provisions of the State Education Law and/or Public Health Law of the State and on the staff of any hospital holding a current operating certificate issued by the State Department of Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power to render care which the aforementioned physician in the exercise of his best judgement may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian