MEDICAL INFORMATION FORM (1 PER PARTICIPANT)

THIS FORM IS STRICTLY CONFIDENTIAL.

Full Name:

Phone: Email:

DOB: Gender:

EMERGENCY CONTACT DETAILS

Full Name:

Phone: Email:

Alternate Phone:

Relationship:

INSURANCE/MEDICARE

Medicare Details	**Private Health Insurance**
Medicare Number:	Insurance Company:
Individual Number:	Policy Number:
Expiry Date:	Group Number:

MEDICAL HISTORY:

Does the participant have any Chronic illnesses (e.g., asthma, diabetes): ☐ Yes ☐ No

Is the participant on any medication: ☐ Yes ☐ No

Does the participant suffer from any allergies? ☐ Yes ☐ No

Is there any medical treatments that the camp staff should be aware of: ☐ Yes ☐ No

Date of last tetanus shot (If known):

CONSENT FOR TREATMENT:

I hereby give consent to the camp staff to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records (including this document) necessary for treatment, referral, billing, or insurance purposes.

Parent/Guardian Name: _____

Signature: _____

Date: _____

MEDICAL INFORMATION DETAILED

If you answered YES to any question in the medical history section, please elaborate here.

Full Name:

DOB: Gender:

CHRONIC ILLNESS

To help assist our staff please provide an overview of any Chronic Illness that the participant may have.

Illness	Length of Illness	Treatment

MEDICATIONS

To help assist our staff please provide an overview of any medication that the participant may have.

Medication	Dosage / Time	Notes

ALLERGIES

To help assist our staff please provide an overview of any Allergies that the participant may have.

Allergy	Severity	Treatment

SURGERY/MEDICAL TREATMENTS

To help assist our staff please provide an overview of any recent surgeries or treatments that may affect the participant.

Type of Surgery/Treatment	Date of Treatment	Is the condition ongoing

OTHER HEALTH INFORMATION:

Please provide any additional health information here: