

ADULT HEALTH FORM

SUMMER CAMP AND CONFERENCE 2007

Name: _____

Any recent illness/injury? _____

What/when: _____

INSURANCE & PHYSICIAN

Policy holder's name: _____ Doctor's Name: _____

Policy Number: _____ Doctor's Phone: (____) _____

Insurance Company & Phone: (____) _____

MEDICATIONS

Name of Medication: _____ For what? _____

Name of Medication: _____ For what? _____

Name of Medication: _____ For what? _____

Which of the following has the participant had?

- _____ Measles
- _____ Chicken Pox
- _____ German Measles
- _____ Mumps

Immunization Dates For: Mo/Yr

Vaccine:

DTP _____	MMR _____
TD (Tetanus/Diphtheria) _____	or Measles _____
Tetanus _____	or Mumps _____
Polio _____	or Rubella _____

Describe any problems with:

Heart Conditions: _____

Blackouts: _____

Convulsions/Seizures: _____

Reactions to Poison Ivy: _____

Reactions to Bee or Wasp Sting: _____

Describe any other medical conditions you have:

List any pertinent information for doctors if you were to become unconscious: _____

Date of Last Physical _____

Date of Last Tetanus Shot _____

EMERGENCY CARE AUTHORIZATION

IN CASE OF SICKNESS OR EMERGENCY

By my notarized signature, I hereby authorize the event director or camp staff to secure medical treatment for me. If needed, I give permission for the attending physician to hospitalize and provide proper treatment. I understand that the insurance provided by the Camp & Conference Program is a limited supplemental policy covering only illness and injury occurring during the event.

SIGNATURE: _____

DATE: _____

Home phone: (____) _____

Work Phone: (____) _____

EMERGENCY CONTACT:

In case of emergency please contact _____

Relationship: _____

Home phone: (____) _____

Work Phone: (____) _____

Cell or Alternate Phone: (____) _____

REGISTRATION WILL NOT BE

ACCEPED

WITHOUT A

NOTORIZED FORM.

NOTARY SIGNATURE: