

Adult/Family Health Form

Transforming Lives!

This form is $\underline{\textbf{required}}$ for attendance. Please fill out $\underline{\textbf{one}}$ section for $\underline{\textbf{each}}$ attendee – this form is for up to $\underline{\textbf{6}}$ family members. For Additional Family Members, please make a $\underline{\textbf{copy}}$ of this form, fill out, and attach prior to mailing

Pri	mary Adult:Last Name	First Name		Middle Initial	
	dress:	City:	State:	Zip:	
Ph	one Numbers: Home Phone, include (Area Code)	Work Phone, include (Area Code)	Cell Phone,	include (Area Code)	
E-r	mail:	Spouse's Work Phone, include (Area Code)	Spouse's Cell F	Phone, include (Area Code)	
PR	IMARY ADULT'S HEALTH HISTORY:			:	
	List any MEDICAL / HEALTH CONDITIONS / RESpertinent past Medical History):				
2 . i	List any PRESCRIPTION MEDICATIONS:				
3.	List any ALLERGIES and REACTIONS to any med				
4 . İ	4. List any dietary needs/concerns (i.e., Celiac disease, diabetic, peanut/nut allergies, etc.):				
5 . i	List recent (last 12 months) hospitalizations and/or	surgeries:			
6 . i	Physician's name: Dr's. Phone #				
	dditional Family Member Information lest Full Name: List any MEDICAL / HEALTH CONDITIONS / RE pertinent past Medical History):	ESTRICTIONS for which we should be aware	, particularly in ca	se of emergency (Include	
2.	List any PRESCRIPTION MEDICATIONS:				
3.	List any ALLERGIES and REACTIONS to any medication, food, or environmental conditions:				
4.	List any dietary needs/concerns (ie: Celiac disease, diabetic, peanut/nut allergies, etc):				
5.	List recent (last 12 months) hospitalizations and/	or surgeries:			
6.	Physician's Name:	Dr's Phone #			
Gu 1.	lest Full Name:List any MEDICAL / HEALTH CONDITIONS / REpertinent past Medical History):		, particularly in ca		
2.	List any PRESCRIPTION MEDICATIONS:				
3.	List any ALLERGIES and REACTIONS to any m	edication, food, or environmental conditions:			
4.	List any dietary needs/concerns (ie: Celiac disea	se, diabetic, peanut/nut allergies, etc):			
5.	List recent (last 12 months) hospitalizations and/	or surgeries			
6.	Physician's Name:	Dr's Pho			

Additional Family Member Information (Cont.) Relationship to Primary adult: **Guest Full Name:** 1. List any MEDICAL / HEALTH CONDITIONS / RESTRICTIONS for which we should be aware, particularly in case of emergency (Include pertinent past Medical History): List any PRESCRIPTION MEDICATIONS: List any ALLERGIES and REACTIONS to any medication, food, or environmental conditions: List any dietary needs/concerns (ie: Celiac disease, diabetic, peanut/nut allergies, etc): List recent (last 12 months) hospitalizations and/or surgeries: __ Dr's Phone # ____ Physician's Name: Relationship to Primary adult: _____ DOB: ____ Guest Full Name: List any MEDICAL / HEALTH CONDITIONS / RESTRICTIONS for which we should be aware, particularly in case of emergency (Include pertinent past Medical History): List any PRESCRIPTION MEDICATIONS: ______ List any ALLERGIES and REACTIONS to any medication, food, or environmental conditions: List any dietary needs/concerns (ie: Celiac disease, diabetic, peanut/nut allergies, etc): _______ List recent (last 12 months) hospitalizations and/or surgeries:____ Physician's Name: ____ Dr's Phone #_____ DOB: **Guest Full Name:** Relationship to Primary adult: ___ List any MEDICAL / HEALTH CONDITIONS / RESTRICTIONS for which we should be aware, particularly in case of emergency (Include pertinent past Medical History): _____ List any PRESCRIPTION MEDICATIONS: List any ALLERGIES and REACTIONS to any medication, food, or environmental conditions: _______ List any dietary needs/concerns (ie: Celiac disease, diabetic, peanut/nut allergies, etc): ________ List recent (last 12 months) hospitalizations and/or surgeries: __ Dr's Phone # Physician's Name: **For Additional Family Members, please make a copy of this form, fill out, and attach prior to mailing. **EMERGENCY CONTACT:** Whom should we contact in case of emergency? (Must be someone <u>not</u> in attendance at camp) Name: City: _____ State: ___ Zip: ____ Address: Home Ph: _____ Work Ph: ____ Cell Ph: ____ -- PLEASE READ CAREFULLY AND SIGN BELOW -PARENT/GUARDIAN AUTHORIZATION: To the best of my knowledge, all information provided on this form is accurate and complete. I submit that all persons listed herein are in good health and have permission to participate in all activities, except as noted. In the event I cannot be reached in an emergency, I understand that every effort will be made to contact the emergency person listed. In the event that they cannot be reached, I hereby give permission to the physician and other medical personnel selected by the camp to hospitalize, secure proper treatment for, and to order routine tests and/or injections and/or

anesthesia and/or x-rays and/or surgery for myself and/or the persons listed herein. I understand that the Camp Director or health care personnel reserves the right to send a person home whose medical condition, in their opinion, becomes unmanageable and/or places other persons at risk. If I, or any person listed herein, have any changes in health status or condition. I understand that this information will need to be resubmitted

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PRIMARY ADULT NAME:	SIGNATURE	DATE			
Signature of Spouse and ALL Dependents 18 & over (attach separate sheet with signature if additional space is needed)					
Print Name:	Signature	Date			
Print Name:	Signature	Date			