Staff

Health History and Medical Consent Form

Name:____

Address:____City:_____________State:__________

Date of Birth: ____/____/____

Insurance Provider: ___________________________Policy #:______________________________

Family Physician: _____________________________ **Phone #:**______________________________

Date of Last Tetanus Shot: ____/____/____

Please list any conditions (allergies, headaches, heart, respiratory, sinus behavioral, etc.), or limitations that may affect the your participation in camp activities.

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Please list any medications you will be taking while at camp.

Medicine: ____________________________**Dosage:** _____________________**Time of Day:** _______________

Medicine: ____________________________**Dosage:** _____________________**Time of Day:** _______________

Medicine: ____________________________**Dosage:** _____________________**Time of Day:** _______________

In case of emergency notify:

Name:____________________ **Relationship:** _________________________

Home Phone: _______________ **Work Phone:**_______________

Person to be notified if above cannot be reached:

Name:____________________ **Relationship:** _________________________

Home Phone: _______________ **Work Phone:**_______________

Consent and for medical treatment:

I hereby give permission to the medical personnel selected by Camp La Verne to provide routine health care; to administer medications; to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me. In the event I cannot be reached in a emergency, I hereby give permission to the physician selected by Camp La Verne to secure and administer treatment, including hospitalization, for the person named above. This form may be photocopied for trips out of camp.

Signature:____ **Date:** ____/____/____

Parent or legal guardian if staff member is under 18 years of age.