HEALTH FORM

Full Name: ______________________________ **Birthday:** ______________ **Age:** ____________

Family Physician: ______________________________ **Office Phone Number:** ______________________

Address: ____

EMERGENCY CONTACT

Name	Relationship to Staff	Phone Numbers

DISEASES

List any of disease(s) and give approximate dates: ____

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ALLERGIES

Drug(s): ____

Food(s): ____

Other allergies: ____

Date of Last Tetanus Shot: ______________________ Date of Last TB Skin Test: ______________________

Current Medication	Dose	Route (mouth, inhailed, etc)	Time

IMPORTANT - THE INFORMATION BELOW MUST BE COMPLETED FOR ATTENDANCE

The information is correct so far as I know, and the person herein described has permission to engage in all prescribed activities except as noted.

Emergency Authorization - I hereby give permission to the medical personnel selected by Deaf Men Zone’s Director/Nurse to order X-rays, routine tests and treatment for my son. In the event of an emergency and I cannot be reached, I hereby give permission to the physician selected by Deaf Men Zone’s Director to hospitalize, secure proper treatment, order injections and/or anesthesia and/or surgery for my son as named above. I further authorize the release of the above medical information to appropriate medical personnel and/or the health coverage insurance company.

Please note if your son is seen in the ER or has an injury, it is the decision of camp admin team to determine if it is safe for your son to remind at camp.

______________________________ ______________________________ ______________

Signature of Parent/Guardian Witness Date

INSURANCE (Verify accuracy of insurance information - Insurance carrier's address is essential.)

Insurance issued in the name of: ____

Name of Insurance Company: ____

Address of Insurance Company: ____

Telephone Number:______________________ Policy Number: ______________________

PLEASE ATTACH A PHOTOCOPY OF BOTH SIDES OF YOUR HEALTH INSURANCE CARD.

I understand that my insurance will be filed as the primary carrier. In the event that no insurance is provided by the family, Shocco Springs Medical Supplement will be the primary within the prescribed limits.

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Signature of Parent/Guardian