Lancaster Presbyterian Church

2017

Staff Medical Form

(18 years and older)

Please Note: This information will **only** be seen and used (by discrete staff and medical personnel) in the case of a medical emergency in which you are unable to provide medical personnel with information or unable to provide us with contact information for your family.

For confidentiality purposes, you may choose to place this form in a sealed envelope with only your name and "Staff Medical Form" written on the front. Sealed envelopes will only be opened if you are unable to provide the necessary information. At the completion of camp forms will either be returned to you sealed (if requested) or shredded while sealed.

This will assist the Camp Medical Staff to give appropriate care, so any changes should be provided upon arrival.

Name of Staff: Last_______________________________First_________________________________

Home Address:____
Street City State Zip

Home Phone# _________________ Sex____ Date of Birth: ___/___/____

Emergency Contact Information:

1st contact name_________________________Phone:____________________Relationship___________

2nd contact name_________________________Phone:____________________Relationship___________

Health Insurance Company:____

Name of Insured:____________________________Relationship to participant:______________________

ID #:________________________________Group No:____

Allergies & Medications:

I have the following condition(s)/allergy(s) ____

I take the following dose(s) of medication(s) ____

____

Primary Care Physician:___________________________________ Phone______________________

Physicians Address: ____

2017

Street	City	State	Zip