



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 Number: _____ Date of Birth: __/__/____

Emergency Contact Information:

1st contact name _____ Phone: _____ Relationship _____

2nd contact name _____ Phone: _____ Relationship _____

Health Insurance Information:

Health Insurance Company: _____

Name of Insured: _____ Relationship to participant: _____

ID #: _____ Group No: _____

Allergies & Medications:

Allergies (please list & state reaction) _____

Medications currently taking: _____

Doctor's Information:

Primary Care Physician: _____ Phone _____

Specialist(s): _____ Phone _____