

SNL CAMP

EMERGENCY MEDICAL INFORMATION

(To be filled out and submitted by all participants)

Check one: Teen Camp _____ Appalachian Girls Camp _____

Participant's Name _____
Last First M.I. Date of Birth

Address _____

Home Phone _____ Email _____

Emergency Contact Person _____
Name Relationship Phone

Health Insurance Company _____

ID/Policy # _____ Group # _____

Employer (adult) _____

Parents Name (youth) _____

Are you a member of an HMO? Y N If yes, name/phone of Primary Care Physician _____

Are you taking any medication at present? Y N Are you allergic to any medications? Y N

List: _____

Non-prescription medications you do not want to receive _____

Have you had a tetanus shot within the last five (5) years? Y N

Are you allergic to any of the following: _____ Bee stings _____ Food allergies _____ Skin allergies

Do you have a history of any of the following medical problems _____ Diabetes _____ Seizures _____ Asthma

Have you ever had hepatitis? Y N Do you have current medical problems or restrictions? Y N
If so, indicate _____

I give permission for the adult team supervisor to transport and request medical attention for my child.

Signature of participant

Parent Signature if participant is under 18

NOTE: The above stated insurance coverage will be applied in all situations requiring medical attention

Please use the back to share any additional information that you would want us to be aware of medically/emotionally.



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