Camp Mechuwana
Adult Camper/Volunteer/Staff Health Information

Camp(s) Attending:____

Name: ____

Mailing Address: ____

____

Telephone #________________________ Cell #______________________________

Date of Birth: ____

Emergency Contact: ____

Telephone/Cell #____

Relationship: ____

Insurance Information

Policy Holder:____

Policy #____________________________ Group #_____________________________

Check One: HMO____ PPO____ Individual Policy _______ Other _______

Insurance Company Name: ____

Address: ____

____

Telephone #_______________________________________

Doctor's Name:____

Address: ____

Telephone #____

Medical Conditions and Medications (please use back of form if necessary, and please print clearly)

1.____

2.____

3.____

4.____

Are you currently taking any medication which may impair your ability to perform functions of your position? (If so, this must be discussed with camp healthcare provider.) Yes____ No____

Food, Bee Sting, & Medication Allergies

____

____

____

Special Dietary Needs

____

____

____

Date of Last Tetanus Shot: ____

I give permission for medical treatment in case of an emergency.

Signature: ____

Date : ______________________________

If you have questions about anything on this form, please contact the camp office at (207) 377-2924.