APPLICATION/MEDICAL AUTHORIZATION

Make check payable to:
_____

Mail with completed registration forms to: **REGISTRATION** **FEE:**
_____ _____
_____

CAMPER INFORMATION

CAMPER'S NAME: _____ AGE: ____ SEX:
HOME PHONE # (_____)_____WORK: (___)_____(If applicable)
ADDRESS: _____
_____
_____
(City) (County) (State) (Zip Code)

It is important to have certain medical information so that any emergency may be taken care of as adequately as possible. Please complete the blanks below and submit other information you feel is applicable:
(1) Date of last physical examination _____

(2) Drug allergies _____

(3) Other allergies (i.e. Bee, etc.) _____

(4) Date of last tetanus immunization _____

(5) Is there a history of: ?heart condition; ?diabetes; ?asthma; ?epilepsy; ?rheumatic fever (6) Are there any physical restrictions? _____
(7) Are you taking any medications at the present time? Yes __ No __ If answer is yes, please list.
_____

Parent/Guardian/Spouse Information

_____ **Phone:** H (_____)_____
NAME of Parent/Guardian/Spouse *(please print)*
Wk (_____)_____
I understand that should a health problem arise, I will be notified, but if I cannot be reached by telephone such medical treatment, including surgery, as deemed necessary by competent medical personnel may be rendered.

_____
Signature - Parent/Guardian/Spouse
Name of Insurance Company: _____ Policy No._____
Name of Family Physician: _____ PHONE: (____)_____

NAME OF TWO PERSONS *OTHER THAN PREVIOUSLY MENTIONED* PARENTS/GUARDIANS, OR SPOUSE WHO MAY BE CONTACTED IN CASE OF ANY EMERGENCY.
NAME: _____ PHONE (____)_____
NAME: _____ PHONE (____)_____
If you are an individual with a disability and wish to acquire this form in an alternative format, please call:
TDD _____

Revised 3/01