Camp Mimanagish Adult Health Form

This information will be kept confidential and will be used only as needed.

Participant Name: _____

Date of Birth: _____

~~~~~~

Primary Emergency Contact

Name and relationship to Participant: _____

Cell Phone: _____Other Phone: _____

Second Emergency Contact

Name and Relationship to Participant: _____

Cell Phone: _____Other Phone: _____

~~~~~~

Health History

Current medications (Could be important in case of emergency): List name, dosage, frequency:

_____

_____

Allergies:

_____

_____

Have you been vaccinated against Covid-19? _____

Please continue on other side

So we can best care for you, please list all conditions, including but not limited to: sleepwalking, convulsions, diabetes, epilepsy, mobility issues, mental health issues, hyperactivity, fatigue, headaches, dizziness…

_____

Anything else we should know medically in order for us to ensure a great camp experience:?

_____

~~~~~~

Primary Physician's Name and Contact Information:

Permission

By signing this form, I verify that the health/medical and insurance information provided on this form is true, accurate and complete. In case of a medical emergency, I give permission to the physician(s) selected by the group's leader to secure proper medical treatment for the participant named on this form. I agree to pay additional costs that arise from such medical treatment if not covered by insurance.

Signature of Participant:

Date:
~~~~~~