

ADULT MEDICAL INFORMATION

In case of an emergency contact:

Name _____ Daytime Phone _____ Relationship _____

Physician _____ Phone _____ Office Location _____

I have difficulty with the following (check all that apply):

____ Asthma _____ Heart Disease _____ Digestion _____ Diabetes _____ Eyes

____ Allergy (explain) _____ Hemophilia _____ Fainting _____ Epilepsy _____ Ears

____ Heart Trouble _____ High Blood Pressure _____ Other (explain)

Allergic to _____

Reaction to _____

Treatment _____

Any further explanation _____

Physical restrictions (accompanied by physician note) _____

I will be taking medications during camp _____ Yes _____ No

Medication _____ For _____

Last Tetanus shot _____ Last physical _____

Certification statement: This health history is correct so far as I know.

Signature of Volunteer _____ Date _____