FORGE Outreach Camps

Permission Regarding Medical Care

Medical Information

(This form must be filled out entirely.)

Name of Participant: _____ Date of Birth: _____

Gender: M / F Phone Number: _____ Email: _____

Address: _____

HEALTH INSURANCE INFORMATION:

(All Camp participants are required to have health insurance coverage during the Camp program. If you will not have active health insurance coverage, you will be required to purchase a short-term health plan for the week. If this is your position, please call 800-873-8957 for further instructions.)

Insurance Company:_____

Policy Holder:_____

Policy Number: _____ Group Number: _____

PARENT OR LEGAL GUARDIAN CONTACT INFORMATION:

Name:_____

Relationship to Student: _____

Address:_____

Home Phone: _____ Cell Phone: _____

CURRENT MEDICATIONS: (list all)

Medication	Dosage	How Often	Special Instructions

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IMMUNIZATION HISTORY:
(List all immunizations you have received and the dates administered, or you can attach your immunization record to this form.)

_____ _____

_____ _____

_____ _____

PERSONAL PHYSICIAN CONTACT INFORMATION:
Physician:_____

Address: _____

Phone Number: _____

Date of your last physical examination: _____

MEDICAL CONDITIONS: (check any that apply)
___ Bleeding Disorder ___ Heart trouble ___ Fainting spells ___ Stomach Issues
___ Asthma ___ Convulsions/seizures ___ Diabetes ___ Nervous condition
___ Hernia ___ Menstrual problems

Explain any above checked items:
_____
_____
_____

Other medical conditions not listed:
_____
_____
_____

List any condition that may require special care, diet, medications:
_____
_____
_____

List any allergies to medications, foods, plants, animals, or insect toxins (Include reaction):
_____
_____

ACKNOWLEDGEMENT:

I, _____, (participating student) acknowledge that all the information listed on this Medical Form is complete and accurate.

Signature of Participant:
_____ Date: _____

Signature of Parent/Legal Guardian (if required):
_____ Date: _____