

NAME _____ Age _____

Health Form North Central Presbytery Senior High - College Camp

HEALTH FORM

Are you taking any medications? If so, list them please _____

Do you have any allergies? If so, to what? _____

List any health problems _____

Any surgeries? _____

Last Tetanus shot _____

Females - If you are pregnant, please inform the camp nurse. This information will be kept confidential.

Physician's name and phone number _____

Dentist's name and phone number _____

Health Insurance Company _____

Policy number _____

Emergency contact _____

How related? _____ Phone number _____

In case of emergency, I hereby give my permission to obtain medical treatment for the above-mentioned person

Parent's signature _____ Date _____

Your signature (if over 18) _____ Date _____

Home address _____
Street City State Zip

Date of birth _____ Home phone _____