

Deaf Youth Retreat

Oct 27-29
2017

Deadline Oct 18th

Office Use

STAFF HEALTH FORM INSURANCE INFORMATION

Blood Type

NAME: _____ Sex _____ Age _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (_____) _____ WORK: (_____) _____

Health INSURANCE POLICY

Name of PolicyHolder: _____

Phone Number: _____ Policy/Group # _____

Type of Coverage: _____

Please include a copy of your insurance card

Doctor's Name: _____ Phone: (_____) _____

Address: _____

ALLERGIES: *Check all that you have*

Allergies	Bee sting	Poison Ivy	Penicillin	Poison Oak	Sumac	Dust
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Any special dietary requirements and/or restrictions:

Last date of your Tetanus shot? _____

Please list any restrictions or limitations:

Check all that you have or use

<i>Asthma</i>	<i>Inhaler</i>	<i>Nebulizer</i>	<i>Diabetic</i>	<i>Sunburns easy</i>
Skin sensitivity due to other medical condition			<i>Eczema</i>	<i>Epipen</i>

Medication or Insulin

Medicine	Dose	Time administered/X per day	Office use

IN CASE OF AN EMERGENCY PLEASE NOTIFY:

NAME: _____

PHONE: (_____) _____ OTHER: (_____) _____

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I, _____ hereby give my permission to camp officials to call a doctor or emergency medical service and for the doctor, hospital or medical service to provide medical, to order injection, anesthesia or surgical care should an emergency arise. It is understood that camp officials will make a conscientious effort to locate the emergency contacts listed above before any action will be taken. If it is not possible to locate emergency contacts listed. I accept the expense of emergency medical or surgical treatment. I hereby authorize DYC and Baptist Hill and its employees and agents to dispense medications and attend to other special needs I may need. I give Deaf Youth Camp's nurse permission to administer all medicines listed as per directions on container or written out.

Signature

Date

Send this, with your registration form *and copy of insurance card*- thank you!