Insurance Information

Is the participant covered by the health insurance/hospital?
Yes ____ No ____

Health Insurance Company (Medical Center)
_____

Name of contact person in case of emergency _____

Telephone: _____

Medications

Will the participant take medication while in the camp?
Yes ____ No ____

____ I want medicines or medical devices taken self-administered.
____ I want medicines or medical devices given by the crew.
____ My son/daughter can carry a limited amount of medication for life-threatening situations (ie, treatment for bee sting, epipen, inhaler).

Please list medication(s):
_____
_____

Dosage(s):
_____
_____

Times of use for each medication:
_____
_____

Reason for taking medicine(s):
_____
_____

Allergies

____ The participant does not suffer any allergic reactions.

The participant is allergic to:
_____
_____

Describe the body's reaction and treatment:
_____
_____
_____

Limitations

Please indicate and clarify any physical, medical, or nutritional limitations, if any:
_____
_____
_____
_____
_____

Emergency Contact

Name: _____
Relationship: _____
Telephone: _____

Doctor: _____
Telephone: _____

Medical Release

Name: _____
Relationship: _____
Signature: _____