CONFIDENTIAL MEDICAL RECORD

PLEASE PRINT LEGIBLY

Camper Name: Last_________________________________ First __________________________ ________ Middle_________________

Birth Date __________________ Gender: Male________ Female_________

Parent Name ____ Home Phone ____

Address ____
Street

____
City State Zip/postal code Country

Person to notify in case of emergency, if other than above: Name ____

Day Phone ___________________ Night Phone__________________

Address ____

Name of Family Physician ____ Phone # ____

1. Does camper have any significant illness or disability? YES NO If yes, please explain, ______________________________
2. Please circle if camper has or has had any of the following:
   asthma chicken pox diabetes epilepsy kidney problems polio rheumatic fever
   tuberculosis other ____
3. Has camper had any other significant illnesses, injuries, or surgeries? YES NO If yes, please explain ___________________

   ____
4. What routine medications does camper take? Please provide dosages:____

   ____
5. Date of last tetanus/diphtheria: _____________________________ Date of last MMR: ______________________________________
6. Is camper allergic to any medications? YES NO If yes, please list ____
7. Does camper have any other allergies? YES NO If yes, please list ____
8. Does camper have any special dietary needs (i.e., allergies, vegetarian, vegan, etc.)? YES NO If yes, please list below:

   ____

HEALTH INSURANCE BILLING INFORMATION

***Please note**: A copy of the front and back of camper's insurance card(s) must also be provided. Please include with this form.*

Insurance Company ____

Claim Form Address ____

I.D. No. ______________________ Group No. ___________________ Name of Policyholder_____________________________

Address of Policyholder ____

I hereby authorize MWROC to disclose information from the camper's medical record to the above named insurance company as needed.

Camper's signature ______________________________________ Date ____

Parent's / Guardian signature _______________________________ Date ____

CONSENT FOR TREATMENT OF A MINOR

I hereby give my consent for treatment of: ____
Last First Middle Birth Date

This authorization covers any procedure which may be deemed advisable by the attending staff physician.

____ _______________________ ____________________
Signature of parent or guardian Relationship to camper Date