MWROC 2014 CONFIDENTIAL MEDICAL RECORD

False or misleading information contained in this form may result in camper not being accepted to MWROC.

Last Name:_________________ **First Name**:________________ **Middle Initial**:__ **DOB**:________ **Gender**: M___ F___

Parent/Guardian Name (if camper is a minor):_________________________________

Phone: Home: _____________________ Cell: _____________________ Work/Other: _____________________

Address: ____
Street

____
City State Zip/postal code Country

Emergency Contact, if other than above:

Name: ______________________________ **Relationship to camper** (circle one): Self Spouse Parent/guardian

Primary Phone: __________________ **Secondary Phone:**_________________

Address:____

Name of Primary Care Physician: ______________________________________ Phone: _____________________

1. **Does camper have any significant illness or disability that we need to be aware of?** YES___ NO___
   Please note: This includes psychological conditions as well as physical ones.
   If yes, please explain: ____
2. **Please circle if camper has or has had any of the following:**_
   asthma chicken pox diabetes epilepsy kidney issues polio rheumatic fever TB 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. **Any allergies to medications?** YES___ NO___ If yes, please list:__________________________________
7. **Any other allergies (include food)?** YES___ NO___ If yes, please list:__________________________________

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:_ ____

Policy ID Number: _____________________ Group Number: __________________

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 signature _____________________________________ Date __________________________

Parent/Guardian signature ______________________________ Date __________________________

CONSENT FOR TREATMENT OF A MINOR

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

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

____ ______________________ _________________
Signature of parent or guardian Relationship to camper Date