

CONFIDENTIAL MEDICAL RECORD

Name of Camp: _____

This completed form must accompany the camper on their first health center visit. It is essential that consent for treatment of a minor is signed by a parent or guardian.

Camper's Name _____ Birth Date _____ Sex _____

Last _____ First _____ Middle _____

Parent Name _____ Home Phone _____

Address _____

Street

City, State

Zip

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 check 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 & their dosages does the camper take? _____

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 _____

HEALTH INSURANCE BILLING INFORMATION

Please note: (1) if any charges are to be billed to an insurance company, a copy of the camp participant's insurance card(s) must also be provided during the visit. (2) **We cannot bill Medicare, Medicaid or Healthwave** as we are not participating providers with these programs.

Insurance Company _____

Claim Form Address _____

I.D. No. _____ Group No. _____ Name of Policyholder _____

Address of Policyholder _____

I hereby authorize Student Health Services to disclose to the above named insurance company, information from the camper's medical record as needed in presenting my claim for benefits.

Camper's signature _____ Date _____

Parent's 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 person authorized to give consent for camper treatment _____ Relationship to camper _____ Date _____