

## 2011 STAFF MEDICAL INFORMATION & RELEASE

(Please Print)

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ M.I. \_\_\_\_\_

Date of Birth: (mm/dd/yy) \_\_\_\_\_ SSN: \_\_\_\_\_

Home Address: \_\_\_\_\_ Email: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Health Insurance Carrier Name: \_\_\_\_\_ Group #: \_\_\_\_\_

Address: \_\_\_\_\_ Policy # \_\_\_\_\_

Explain any medical condition we should be aware of: \_\_\_\_\_  
\_\_\_\_\_

Note any prescription medications currently used: \_\_\_\_\_  
\_\_\_\_\_

Note allergies: \_\_\_\_\_

Date of last Tetanus: \_\_\_\_\_ Do you have:  Epilepsy?  Diabetes?  Asthma?

List the name and phone of one individual that can be called in an emergency:

Name: \_\_\_\_\_ Phone \_\_\_\_\_

In an emergency, I hereby give permission to a licensed physician to hospitalize and secure proper treatment, anesthesia, surgery for myself. In case of emergency return for medical reasons the undersigned will be responsible for covering any added expense.

I realize that I participate at my own risk. I also agree not to hold responsible Tri-State Camp and/or Camp Maurer for any and all losses, claims, actions, or rights of action which may hereafter be made by me or on my behalf arising from or growing out of injuries claimed to have been sustained by me during my participation at Tri-State Camp, July 18-22, 2011.

Signature of Participant: \_\_\_\_\_ Date Signed: \_\_\_\_\_