ADULT HEALTH INFORMATION FORM
(Please print or type)

Participant's Name____

Event: ____ Event Date______________________

E-mail Address____

Address________________________________City___________________State_____Zip Code__________

Date of Birth__________________________ Sex_______ Home Phone #______________________

Phone Numbers: Home_____________________________ Work _________________________________

Emergency Contact Person_____________________________________ Relationship__________________________

Phone Numbers: Home_____________________________ Work _________________________________

Physician's Name____________________________________ Office Phone Number___________________________

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ALLERGIES: Please indicate any allergies below:

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HEALTH CONDITIONS: Please indicate any chronic conditions or health issues that the camp should be made aware of that would limit participation in event activities [Please describe]:

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MEDICATIONS

Please list all **prescription medications** the participant will be taking at camp and the reason the medication has been prescribed:

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PERMISSION TO TREAT: Please complete the following section.

Please read carefully and sign the following statement:

I do give permission for the responsible persons at Hebron Center to sign for emergency treatment for me, the participant, whose name appears on this form.

I am willing to use my own insurance for any medical expenses which I, the participant, may require.

Insurance Company________________________________ Policy Number____

Signature of participant ____ Date______________________