HUNT HILL AUDUBON SANCTUARY MEDICAL FORM

PROGRAM:_____ DATE:_____

FULL NAME:_____

Street, City, State, Zip:_____

PHONE: (H) _____(C)_____(W)_____

DATE OF BIRTH:_____ AGE: _____

Our camp provides first aid only. In the event of illness, or injury, a doctor will be called at the participant's expense. In an emergency, the camper will be transported to Spooner Memorial Hospital, unless preference is noted here:

_____

In case of emergency, who should be notified?

NAME: _____ RELATIONSHIP:_____

PHONE: (H) _____(C) _____(W)_____

SECOND CONTACT:_____ RELATIONSHIP:_____

PHONE: (H) _____(C) _____(W)_____

FAMILY DR: _____CLINIC_____

ADDRESS_____PHONE_____

HEALTH CONDITIONS AND ALLERGIES

Are your activities in any way limited now?_____

_____

Have you been ill recently? ____With what? _____

_____

Are you allergic to any medication? (specify) _____

_____

Are you allergic to insects or plants we might encounter on a fieldtrip? _____

_____

Are you currently taking any medication the staff should be aware of? _____

_____

Date last tetanus booster: _____

DIETARY NEEDS AND FOOD ALLERGIES

Please list any special dietary needs or food allergies that our staff should be aware of when preparing meals. (Please review our Special Dietary Policy for more information and possible meal surcharges.)

_____

_____

PAST MEDICAL HISTORY

Any history of asthma or severe allergic reaction? _____

Previous surgery? _____

Previous severe injuries (broken bones – major trauma)? _____

Previous hospitalization? _____

_____

Any problem requiring regular medical attention? _____

_____

Signature: _____Date_____