youthfront

Volunteer Staff Medical Information

West or LaCygne

circle one

Name _____ Home # (____) ____-_____

Address _____ Work # (____) ____-_____

City _____ State _____ Zip _____

Name of hospitalization insurance company _____

Policy # _____ Policy holder's name _____

Family Doctor _____ Doctor's # (_____) _____-_____

Person to be notified in case of emergency _____

Relationship _____ Home # (_____) _____-_____ Work # (_____) _____-_____

Current medication(s) _____

Reason for taking medication(s) _____

Circle any allergies: Hay Fever Poison Ivy Insect Sting Penicillin Other _____

List any dietary allergies _____

Do you have seizures? ❑ Yes ❑ No Date of last occurrence _____

List your past medical treatment if any _____

_____

List any camp activity from which you should be exempted for health reasons _____

_____

Please describe any current physical, mental or psychological conditions requiring medication, treatment or special restrictions or considerations while at camp _____

_____

Immunization Record	Please list the dates of these vaccinations:	Last Tetnus Shot: / /
DPT (Diptheria Pertussis Tetnus): / /	Hepititus B: / /	Varicella (Chicken Pox): / /
MMR (Measles, Mumps, Rebella): / /	Polio: / /	HIB (Heamophilus Influenza Bacteria): / /

In consideration for being allowed to participate in Youthfront Camp West/Youthfront Camp LaCygne, I agree to hold harmless and release Youthfront, its directors, officers, employees, volunteers and agents from liability for any fault, mistake, negligence, or omission causing damage, loss, injury, or death to me (hereinafter referred to jointly as Damage) arising from my attendance at the Camp, including any Damage arising from the provision of emergency medical treatment.

I have answered the above statements truthfully and completely.

Signature _____ Date _____