

Health Information Form

Provide all health related information that the Camp may need to know so that the Camp Participant's experience is positive and safe. This form must be returned seven (7) days prior to the first day of the Camp.

Please note that there are no medical care facilities available for Participants on the University's campus. Medical care, if required, will be provided by the regional emergency medical services system.

Participant's Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_  Male  Female

**Medical Insurance Information**

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Participant's Full Name \_\_\_\_\_ Participant's Date of Birth \_\_\_\_\_

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Insurance Subscriber's Full Name \_\_\_\_\_ Subscriber's Relationship to Participant \_\_\_\_\_

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Insurance Company Name \_\_\_\_\_

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Group and Policy Number \_\_\_\_\_

**Emergency Contact Information**

Contact #1	Contact #2
Name _____	Name _____
Phone _____	Phone _____
Email _____	Email _____

**Does the Participant currently have any:**

Drug allergies:  No  If Yes, specify: \_\_\_\_\_

Food allergies:  No  If Yes, specify: \_\_\_\_\_

Other allergies:  No  If Yes, specify: \_\_\_\_\_

**Are there any health conditions (physical or mental) the Camp should be aware of, including conditions requiring the use of medication:**

None  If Yes, specify, \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Is there any other conditions or information not provided that may require an accommodation, including for a disability, injury, or illness:**

None  If Yes, specify, \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Participant:**

**Parent or Legal Guardian:**

(Necessary if Participant is under 18 years of age)

Printed Name: \_\_\_\_\_ Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Signature: \_\_\_\_\_