## Susquehanna Conference Camp & Retreat Ministry

# ADULT MEDICAL FORM

Camp Center:__________________________ Program Event:________________________________ Dates:__________

Name: ______________________________________________________ Phone: (_____)_________ ___ _______

Address: __________________________________________________________________________________________

City: ________________________________________________ State: _____ Zip: ___________________

Email:_____________________________________________ _____________________________________________

Birth Date:___________ __ ____ Age at event:______ Gender:_____________ Height:_________ Weight:_________

Church you attend (if any): ________________________________________________________________________

Please list any allergies, severity, and reaction:

Please list any ongoing medical concerns:

Please list any medications you are currently taking:

NOTE: If you are serving as staff/volunteer and caring for campers, please turn in all medications to the camp nurse.

Date of last physical examination: __________________________________________________________________

Health Insurance Provider:__________________________________________________________________________

ID/Policy #:_____________________________________ Group #:________________________________________

Primary Care Physician:_____________________________________ Phone:________________________________

Emergency Contact: _______________________________________ Relationship:___________________________

Phone #1:___________________________________________ Phone #2:___________________________________

Signature________________________________________________________ Date________________________