

Medical Information - please print clearly or type

Name- First: _____ Last: _____ Middle: _____

Date of Birth: _____ Age: _____ Male/Female: _____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact: (1) Name: _____ Relationship: _____

Phone - Work: _____ Home: _____ Cell: _____

Emergency Contact: (2) Name: _____ Relationship: _____

Phone - Work: _____ Home: _____ Cell: _____

Medical History- if you answered yes to any, please describe occurrences & list medications.

Epilepsy: _____ Asthma: _____ Diabetes: _____ Heart disease: _____ Current Medications: _____

Bee sting allergy: _____ Anaphylactic shock: _____ Other allergies: _____

Describe what happens when contact is made with allergen: (rash, hives, anaphylaxis, etc)

When is the last time camper had an allergic reaction: _____

Known allergy to any medications: _____

** if you have asthma, please plan on bringing three FULL inhalers and indicate: _____

Date of last tetanus booster: _____ Vegetarian: _____ Any other dietary

needs, physical or psychological problems, which might affect the safety of yourself or

other members of the group, or other information necessary for my care & treatment:

Insurance policy for health, hospitalization or medical care, name of insurer:

_____ Policy # _____ Certificate/Group # _____

I verify that the above information is accurate and complete. In the event of my, or my child or ward's, injury or illness, I give the Turtle Island Preserve staff and the medical staff at the facility to which I or they may be transported permission to render the medical treatment that the providers in their discretion elect to administer.

Signature of participant: _____ Date: _____

If under 18 years of age signature of parent/ legal guardian required: _____

Printed name(s) of both: _____ / _____