Atlantic Northeast District Women's Fellowship
WOMEN'S CAMP

Adult Health Information

Please complete and bring to camp.

ALL CAMP PARTICIPANTS MUST FILL OUT HEALTH FORM!

Name:_____ Home Phone:_____

Address: _____

Church Affiliation: _____

Date of Birth (optional): _____ Date of last Tetanus Shot: _____

EMERGENCY INFORMATION

Emergency Contact: _____ Relationship: _____

Home/Cell Phone: _____ Business Phone: _____

Home Address: _____

Business Address: _____

Physician: _____ Phone: _____

Address: _____

Medical/Hospital Insurance Carrier: _____

Policy/Group #: _____

HEALTH HISTORY

ILLNESS/INJURIES (Please check those that are chronic or recurring.)

- ☐ Asthma
- ☐ Convulsions
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Heart Disease
- ☐ Kidney Disease
- ☐ Other (please specify)
- ☐ _____
- ☐ _____
- ☐ _____

ALLERGIES (Please check those that apply and give details.)

- ☐ Animals: _____
- ☐ Food: _____
- ☐ Insect Stings: _____
- ☐ Medicines/Drugs: _____
- ☐ Other: _____

OTHER HEALTH CONDITIONS (Please check all that apply.)

- ☐ Wear Contact Lenses
- ☐ Wear Glasses
- ☐ Hearing Impairment
- ☐ Sleep Walking
- ☐ Dental Appliances
- ☐ Other (please specify)
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Date of last health exam: _____

Are you currently under a physician's care for a medical problem? (Please circle.) Yes No

If yes, please explain: _____

List below the medications you are taking (include dosage):

_____ _____
_____ _____
_____ _____

Please check those statements below that apply since your last health exam:

- ☐ a serious injury requiring medical attention.
- ☐ an illness lasting longer than one week.
- ☐ a surgical operation or fracture.
- ☐ treatment in a hospital as inpatient or in the emergency room

Please explain any check answers (include dates): _____
_____

Are you restricted from participating in any physical activity? (Please circle.) Yes No

If yes, please explain: _____
_____

Please provide any other information about yourself, which might be needed in an emergency.
_____

AUTHORIZATION FOR EMERGENCY TREATMENT

In case of medical emergency, I understand every effort will be made to reach my Emergency Contact Person who is authorized to act on my behalf. In the event that person cannot be reached, I hereby give permission to the physician selected by authorized ANE Women's Fellowship personnel to hospitalize, secure proper treatment, and order injection, anesthesia or surgery for me.

Signature: _____ Date: _____

Sign below only if you decline to sign the release above.

I have been offered the opportunity to authorize emergency medical care as set for the above and decline to so authorize said emergency medical care without my approval and accept such complications as may occur should said medical care be needed and unavailable due to my being unable to provide the same.

Signature: _____ Date: _____