



**CAMP COPASS, INC.**  
 8200 E. McKinney Street, Denton, TX 76208  
 940-565-0050 (phone) 940-382-9984(fax)  
[www.campcopass.com](http://www.campcopass.com)

**CAMP COPASS STAFF HEALTH FORM**

Name: \_\_\_\_\_ Sex: (M/F) \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Street Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number: \_\_\_\_\_ email address: \_\_\_\_\_

Parent/Emergency contact: Name \_\_\_\_\_ Cell \_\_\_\_\_ Relationship \_\_\_\_\_

Parent/Emergency contact email: \_\_\_\_\_

**INSURANCE INFORMATION (Please attach a copy of your insurance card)**

Insured's Member's Name \_\_\_\_\_ Member ID \_\_\_\_\_

Health Insurance Provider \_\_\_\_\_ Group ID \_\_\_\_\_

Health Insurance Provider Phone Number(s) \_\_\_\_\_

Primary Care Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

**GENERAL HEALTH INFORMATION (attach additional copies of information if necessary)**

List any health concerns/issues that would be relevant to an attending physician in the case of an emergency:

\_\_\_\_\_

List any chronic or recurring illnesses or diseases:

\_\_\_\_\_

List any food, medication, or other significant allergies:

\_\_\_\_\_

List any pre-existing injuries which occurred before coming to camp:

\_\_\_\_\_

\_\_\_\_\_  
**Signature of Summer Staffer**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed Name**