The Ballibay Camps

Staff Medical Form

1660 Ballibay Road Wyalusing, PA 18853 570-746-3223 office@ballibaycamps.com

Full Name: _____

Date of Birth: _____

Home Address: *(as it appears on your ID)* _____
Street Address City State Zip Code

Emergency Contact Full Name: _____

EC's Home Address: _____
Street Address City State Zip Code

EC's Phone Number: _____

Second EC's Name: _____

2nd EC's Home Address: _____
Street Address City State Zip Code

2nd EC's Phone Number: _____

MEDICAL HISTORY

Chronic Medical/Psychological Conditions: _____

_____

_____

_____

Surgeries:

_____ at age _____

_____ at age _____

Major Illnesses/Injuries:

_____ at age _____

_____ at age _____

_____ at age _____

I am:

- ☐ Vegetarian
- ☐ Vegan
- ☐ Gluten Free
- ☐ Lactose Intolerant
- ☐ Allergic to: (list)

_____

_____

_____

_____

_____

Immunizations:

_____ at age _____ _____ at age _____

_____ at age _____ _____ at age _____

_____ at age _____ _____ at age _____

MEDICATIONS

Medication: _____ Dosage: _____ When: _____

Medication: _____ Dosage: _____ When: _____

Medication: _____ Dosage: _____ When: _____

Medication: _____ Dosage: _____ When: _____

Medication: _____ Dosage: _____ When: _____

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PHYSICIAN: *Please note any restrictions to this person's activities or precautions which should be taken with this person. Can this person participate in activities without restriction?*

Patient's Full Name: _____ Date: _____

Comments: _____

_____

_____

_____

Abnormalities:

EENT/Neck: _____

Chest: _____

CV: _____

Respritory: _____

Musculo Skeletal & Neural: _____

GU & Genital (Hernia): _____

Physician's Signature _____ Date: _____

Physician's Phone #: _____

Physician's Address: _____

PLEASE READ: Permission is hereby given for the camp directors to authorize medical, dental or hospital attention for me should I become incapable to do so by reason of medical emergency. In signing this medical form, I give permission for medical, dental or hospital attention to be given to me, and attest that all information is complete and correct and that I have listed all relevant insurance information below.

Insurance Carrier: _____

ID #: _____ Name on Card: _____

PLEASE INCUDE A PHOTOCOPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD!

Information: Is there any information, medical or otherwise, that our medical staff should be aware of? Naturally, your comments are confidential.