CAMP BALLIBAY STAFF MEDICAL FORM

Ballibay Camps, Inc. 1660 Ballibay Road Wyalusing, PA 18853 USA 570 746 3223 office@ballibaycamps.com

Full Legal Name (as it appears on your ID) _____ Birth date _____

Preferred Name and pronouns (how you would like to be addressed) _____

Home Address (as it appears on your ID) _____

Mobile phone number _____

Emergency Contacts

Emergency Contact #1 _____ Relationship to you _____

Emergency Contact #1 phone number _____ Alternate phone number _____

Emergency Contact #2 _____ Relationship to you _____

Emergency Contact #2 phone number _____ Alternate phone number _____

Diet

Describe your diet (omnivore, vegetarian, vegan, gluten-free, etc...) _____

_____

Allergies

Allergic to: _____ Severity of allergy (mild, severe), symptoms _____

Allergic to: _____ Severity, symptoms _____

Allergic to: _____ Severity, symptoms _____

Allergic to: _____ Severity, symptoms _____

If any of your allergies require specific treatment, please describe in detail _____

_____

_____

Please describe any medical or psychological conditions

Condition: _____ Severity, symptoms _____

Required Accommodations: _____

Instructions to medical staff: _____

Condition: _____ Severity, symptoms _____

Required Accommodations: _____

Instructions to medical staff: _____

Condition: _____ Severity, symptoms _____

Required Accommodations: _____

Instructions to medical staff: _____

Medications

Medication: _____ Dosage and Schedule _____

Medication: _____ Dosage and Schedule _____

Medication: _____ Dosage and Schedule _____

Medication: _____ Dosage and Schedule _____

Medication: _____ Dosage and Schedule _____

Medication: _____ Dosage and Schedule _____

Other information

Is there any information, medical or otherwise, that our medical staff should be aware of in order to help insure your physical, mental, and emotional safety and well-being at camp?

_____

_____

_____

_____

_____

_____

_____

_____

_____

Insurance information

Medical Insurance Provider: _____ ID#_____ Group# _____

Hospital Insurance Provider: _____ ID#_____ Group# _____

Prescription Insurance Provider: _____ ID#_____ RxBIN _____ PCN _____

PLEASE ATTACH COPIES OF YOUR INSURANCE CARDS

Agreement

Permission is hereby given for the camp directors to authorize medical, dental or hospital attention for me should I become incapable to do so for any reason. In signing this medical form, I give permission for medical, dental or hospital attention to be given to me, and attest that all information provided on this form is complete and correct, that I have provided all information relevant to insuring my physical, mental, and emotional health at camp, and that I have listed and attached my complete insurance information.

Signed _____

Date_____