

Participant Medical Information Form

For:

Participant Health Information

Is the participant covered by family medical / hospital insurance? Yes No

Insurance Company

Name of Carrier

Policy Number

Insurance Company Phone Number

Subscriber's Name

Subscriber's Date of Birth

Immunizations Current Not Current

Date of Last Tetanus Shot

Does the participant require special dietary considerations? Yes No

Please describe dietary restrictions (if applicable)

Does the participant have any allergies? Yes No

Please describe allergies (if applicable).

Does the participant have any physical restrictions? Yes No

Please describe physical restrictions (if applicable).

Does the participant take any prescribed medications? Yes No

If there is any additional medical/health history information we should be aware of, please enter it here.

Please enter any prescribed medications on the following page. If not applicable, please skip the following page.

Participant Medical Information Form (continued)

For:

With my electronic signature, I hereby acknowledge that all of the above information is, to the best of my knowledge, correct and current. I hereby authorize The Chautauqua staff, Camp Health Officer and/or Summer Camp Directorship to make emergency medical decisions for me and/or my child and I understand that my insurance coverage will be primary coverage. If the group I and/or my child is attending with has insurance, the respective group is second coverage and Chautauqua will be third and for accidents only, no illness coverage.

Additionally, I attest that I have the authority to complete and sign this form and that I am the legal guardian for myself and/or the individual concerned in this document.

Signature _____ Date _____