

**CAMP NOCK-A-MIXON STAFF MEDICAL FORM**  
**(Complete front and back and return to camp by June 15)**

**Part I - Personal Information**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Home Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Sex \_\_\_\_\_ Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

**Part II - To be completed by a physician**

**Immunization information must be provided with date of most recent inoculation.**

DTP or DT \_\_\_\_\_ HEP B \_\_\_\_\_ TETANAS \_\_\_\_\_ POLIO \_\_\_\_\_

MMR \_\_\_\_\_ or MEASLES \_\_\_\_\_ MUMPS \_\_\_\_\_ RUBELLA \_\_\_\_\_

CHICKEN POX \_\_\_\_\_ MENINGOCOCCAL VACCINE \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_

Presently under medical care for the following conditions \_\_\_\_\_  
\_\_\_\_\_

Medications to be administered at camp (name, dosage, frequency) \_\_\_\_\_

Medication Allergies \_\_\_\_\_

The above patient is \_\_\_\_\_ is not \_\_\_\_\_ able to participate in an active camp program. I agree that the above information is correct and complete.

Physicians signature \_\_\_\_\_ Date \_\_\_\_\_

Physician's License Number \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

**Part III - Insurance Information**

(Must provide a photocopy of insurance card front and back)

Name of insurance company \_\_\_\_\_

Card # \_\_\_\_\_

**Part IV – Additional Information**

Do you take medicine on a daily basis? \_\_\_\_\_

Med #1 \_\_\_\_\_ Why? \_\_\_\_\_

Med #2 \_\_\_\_\_ Why? \_\_\_\_\_

Medication Allergies? (If yes, please list) \_\_\_\_\_

\_\_\_\_\_

Food Allergies? \_\_\_\_\_

Dietary restrictions \_\_\_\_\_

I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for me or my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

It is my intention that the camp be treated as acting *in loco parentis* if the person herein named is a minor. Further, it is my intention that appropriate representatives of the camp be treated as “personal representatives” for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR 164.510 (b) ) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary (i) to provide relevant information to the camp representatives related to the person’s ability to participate in activities; and ( ii) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child’s health status.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for out of camp trips.

Counselor Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent’s signature \_\_\_\_\_ Date \_\_\_\_\_  
(if under 18)