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#_____

Emergency contact: Name_____ Number_____

Part II - To be completed by a physician

Immunization information must be provided with date of most recent innoculation.

DTP or DT_____ HEP B_____ TETANAS_____ POLIO_____

MMR_____ or MEASLES_____ MUMPS_____ RUBELLA_____

CHICKEN POX_____ MENINGICOCCAL 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.

I, on behalf of myself(or my child), certify that I have provided full and complete disclosure of all medical, psychological and emotional conditions, including medications taken or withheld during camp. I authorize the camp medical staff to discuss any medical conditions with all necessary parties when the medical staff believes such communication is in my (or my child's) best interest.

Counselor Signature_____ Date _____

Parent's signature _____ Date _____
(if under 18)