Emergency Information Form – Adults at Camp de Benneville Pines

Name ____**SS#** __________________________ **DOB**___________________

Address ____ **City** ________________________**ST** _______ **Zip** ____________

Home Phone# ____ **Cell Phone#** ____

Medical Insurance Company ______________________________________ **Phone#** ____

Policy# ____ **Group#** ____

Emergency Contact (not at camp)

Name ____ **Phone#1** ____

Phone#2 ____ **Email/SMS** ______________________________________

My immunizations are up-to-date YES NO Date of last tetanus shot ____________________________________

Known allergies to food, medication and/or anesthetics, environmental factors:

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Known medical problems/conditions and medical treatment that may be needed at camp:

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I understand that if I become injured or ill while at camp, the Health Supervisor is authorized to determine if I require care outside the bounds of what is available in our wilderness setting. Due to de Benneville's isolation and elevation, any camper remaining ill for more than 12 hours may be asked to leave camp. Camper may only return with authorization by a physician. I have been made aware that it may take 45 minutes or more, for paramedics to respond to a 911 emergency call. If road conditions are icy or hazardous, it may take substantially longer. I agree to follow the safety rules of the camp.

This form is for use by the Medical Supervisor during camp only. When checking out at the end of your retreat, the form will be returned to you. If you do not pick up your form at the end of camp, it will be shredded. Camp policy does not include retaining medical records for adult campers.

I hereby give permission for the camp first aid person to provide routine health care and emergency medical treatment, including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes. I give permission to the retreat organizers or the camp staff to arrange necessary related transportation. In the event of an emergency, I hereby give permission to the physician selected by the retreat organizers or camp staff to secure and administer treatment, including hospitalization.

Signature of Adult Camper/Participant____ **Date** ____________________

Although I understand that my medical information is being requested only so that medical treatment can be provided in case of an emergency, loss of consciousness or inability to make a decision on my own, and that not having this information may make it impossible for the Medical Supervisor to provide appropriate medical care, I wish to decline to provide the requested medical information.

Signature of Adult Camper/Participant____ **Date** _____________________