

Episcopal Diocese of Southern Ohio- Adult Health History

Completed by All over 17 years of age

Full Name (please print) _____

Camping Session Attending _____

Date of Last Tetanus Shot _____

Medical Diagnosis (es) _____

(attach additional sheets with information to the back of this form. Thanks!)

<p><u>Medication Allergies:</u></p> <p>_____</p>	<p><u>Food Allergies:</u></p> <p>_____</p>	<p><u>Other Allergies:</u></p> <p>Insect bites/stings _____</p> <p>Poison Ivy _____</p> <p>Seasonal _____</p> <p>Other _____</p>
<p><u>Health Problems:</u></p> <p>Diabetes _____</p> <p>Cardiac _____</p> <p>Asthma _____</p> <p>Epilepsy _____</p> <p>Mental disability _____</p> <p>Physical disability _____</p> <p>Emotional disability _____</p> <p>Other _____</p> <p>If yes to above, specify:</p> <p>_____</p> <p>_____</p> <p>Tobacco product use:</p> <p>Yes _____ No _____</p> <p>Variety _____</p>	<p><u>Medications:</u></p> <p>Note: if you have asthma, do you have a rescue inhaler?</p> <p>Yes _____ No _____</p> <p>(If no, you must get letter from health care provider stating you do not need one, or you must have on prescribed.)</p> <p>Other Meds (Name and dose):</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><u>Restrictions:</u></p> <p>Activity: Yes _____ No _____</p> <p>Dietary: Yes _____ No _____</p> <p>If yes, please specify:</p> <p>_____</p> <p>_____</p> <p>_____</p>

Medical insurance information:

Company: _____ Policy Number _____

Advanced authorization telephone number is necessary () _____ - _____

Health care provider:

Primary Health Care Provider: _____ Telephone: () _____ - _____

Dentist: _____ Telephone: () _____ - _____

In case of emergency contact: _____

Relationship : _____ Telephone: () _____ - _____

RELEASE

In the event that I am incapacitated and cannot be consulted about my treatment in an emergency in which I am involved at camp, I hereby give my permission to the physician or dentist selected by the Diocese of Southern Ohio Camping Program to hospitalize, secure proper treatment and /or to order an injection, anesthesia, or surgery for me. Procter Camp and Conference Center and the Diocese of Southern Ohio will not be held liable.

I give permission for any quotes or pictures taken during camp to be used for promotional materials.

Signature: _____ Date: _____

Signature (of parent or guardian if minor) _____ Date: _____