ADULT CAMPER HEALTH HISTORY

Mail this form to:
Pioneer Camp & Retreat Center, Inc.
9324 Lake Shore Road
Angola NY 14006

Name: _____
First Middle Last

Dates attending camp: from _____ to _____
Month/Day/Year Month/Day Year

☐ Male ☐ Female Birth Date _____ Age on arrival at Camp: _____

This form is for emergency purposes ONLY! Please return to our office 14 days before your arrival. Please be sure to send a copy of your insurance card.

Name of Primary Care Physician:_____ Phone:_____

Home Address:_____
Mailing Address City State Zip

In Case of Emergency Contact:

Name: _____Relationship to Camper: _____

Preferred Phone: (_____) _____Secondary Phone(_____) _____

Home Address :_____
(if different from above) Mailing Address City State Zip

Allergies: ☐ No known allergies ☐ I am allergic to: ☐ Food ☐ Medicine
☐ The environment (insect stings, hay fever, etc.) ☐ Other

Describe what you are allergic to and the reaction seen.

Diet & Nutrition: ☐ I eat a regular diet. ☐ I eat a regular vegetarian diet.
☐ I have special food needs. **Describe dietary needs.**

Medications: Please list *ALL* medications you take.
In case of an emergency, it is essential that we know if you are on any medications.

Please list below each medication by name, dose, and frequency.

Name of medication	Dose	Frequency

Authorization for Health Care:

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the my health for both routine health care and in emergency situations. I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia or surgery for myself. I understand the information on this form will be shared on a "need to know" basis with camp staff and health care provider(s). I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my health record from providers who treat me and these providers may talk with camp staff about my health status.

Signature of Camper:_____ Date_____