AFS FLUTE CAMP EMERGENCY INFORMATION

Name_____Date of Birth_____

Address_____Phone #_____

Emergency Contact Name_____Phone#_____

Religion (Opt.)_____

Physician_____Phone#_____

Address_____

Preferred Hospital_____Hospitalization Insurance_____

History of Diabetes, Epilepsy or Asthma_____

Allergies to Sulpha, Penicillin, etc._____List Any Food Allergies_____

List any Medications Currently Taking_____

Identify any medical conditions that may affect your participation in any of the camp activities_____

_____

Permission to Administer Anesthetic? Yes_____ No_____

_____ _____

Signature of Participant Date Signature of Parent/Guardian if under 18 Date

This information will be used for medical purposes only. Any prescription medications being taken by the participant need to be in the original prescription container with the patient's name on it.