camPossible! ADULT HEALTH FORM

Name (Last, First, Initial)		Sex		Birth
Address	City	State	Zip	Phone (Indicate: Home or Cell)
				( )
In Emergency Notify	Address	Relationship		Phone
				(H)
Comments:		(W)		(C)

Insurance Information, please complete the following:		
Carrier	ID Number	Group Number
Member Services Phone Number	Address	

Please list any serious allergies:

If there is a condition that we should be aware of, please describe here:

PLEASE LIST CURRENT MEDICATIONS BEING TAKEN BELOW— INCLUDE DOSAGE AND ANY POTENTIAL HARMFUL INTERACTIONS (e.g. food, medications, environmental)

I certify that to the best of my knowledge this health history is complete and accurate. I am in good health and able to participate in this event/assignment.

Signature: **Date:**

HEALTH INFORMATION PRIVACY STATEMENT

The **Adult Health Form** is for health care concerns at camPossible! only. All records will be handled by staff/volunteers whose job includes processing or using this information for the benefit of the participant. All medical records will be held in limited access by the health care supervisor of the specific event. Minimal necessary information may be shared with event staff/volunteers in order to provide adequate participant safety and health care.

The health form will be retained by EFNCIL until it is destroyed. All forms/records with noted treatment will be retained for seven years. Access to the information will be limited, but copies may be requested from EFNCIL, by the participant or their legal representative.

I have read the above procedures for handling the health form information and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

Signature:_____Date:_____