(This form is due in the camp office at least two (2) weeks prior to the start of your session.)

HEALTH HISTORY FORM
(Adult)

This form must be filled out completely and returned to *Holmes Camp & Retreat Center; 60 Denton Lake Rd,* Holmes, NY 12531

Name:_____ Name Called: _____
Last Name First Name Middle Name

Address:_____
Street Apt. #

City:_____ State:_____ Zip:_____

Sex: _____ (for medical purposes) Gender: _____ Date of Birth:___/___/___

Home Phone:_____Cell Phone:_____

Email Address:_____

MEDICAL OR EMERGENCY CONTACT INFORMATION

Emergency contact:_____ Relationship:_____

Emergency phone:_____ Emergency day phone:_____

Other emergency names (& relationships), and phone numbers the Holmes Presbyterian Camp should have:

_____

PHYSICIAN AND INSURANCE INFORMATION:

Name of Physician/Clinic:_____ Phone:_____

Date of last physical exam:_____ Date of Last Tetanus Booster:_____

Family Health Insurance Co:(Name)_____

(Address) _____ Phone:_____

Policy Number:_____ Group Number:_____

CURRENT MEDICATION: (Please list)

_____

_____

_____

ALLERGIES: (Please list)

_____

_____

_____

Note: Your insurance will be the primary coverage. Holmes Presbyterian Camp & Conference Center provides coverage for sickness and accidents up to the limits of the policy and will be the secondary coverage.

AUTHORIZATIONS:

In signing this authorization, I hereby certify that the information herein is correct, give permission for the use of photographs and videos including me or articles written by me to be used in camp publicity including the Holmes Presbyterian Camp and Conference Center website and internet sites promoting or reporting on Holmes, and authorize transportation to and from public transportation or approved out-of-camp activities. I hereby give permission to the medical personnel selected by the camp director to provide routine health care/ to administer medications; to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me. I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, injection, anesthesia, or surgery for the person named above. This completed form may be photocopied for trips out of camp.

Signature:_____ Date:_____