Tri State

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**Indianola, IA 50125**
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# STAFF MEDICAL INFORMATION & RELEASE

(Please Print)
Last Name: _____ First: _____ M.I. _____

Date of Birth: (mm/dd/yy) _____ SSN: _____

Home Address: _____ Email: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Employer: _____ Work Phone: _____

Health Insurance Carrier Name: _____ Group #: _____

Address: _____ Policy # _____

Explain any medical condition we should be aware of: _____
_____

Note any prescription medications currently used: _____
_____

Note allergies: _____

Date of last Tetanus: _____ Do you have: □ Epilepsy? □ Diabetes? □ Asthma?

List the name and phone of one individual that can be called in an emergency:

Name: _____ Phone _____

In an emergency, I hereby give permission to a licensed physician to hospitalize and secure proper treatment, anesthesia, surgery for myself. In case of emergency return for medical reasons the undersigned will be responsible for covering any added expense.

I realize that I participate at my own risk. I also agree not to hold responsible Tri-State Camp and/or Camp Maurer for any and all losses, claims, actions, or rights of action which may hereafter be made by me or on my behalf arising from or growing out of injuries claimed to have been sustained by me during my participation at Tri-State Camp.

Signature of Participant: _____ Date Signed: _____