THE PHOEBE NEEDLES CENTER

ADULT MEDICAL INFORMATION FORM

ADULT CAMPER'S NAME ____

(first) (middle) (last) (preferred)

Address ____

City, State, Zip Code ____

Preferred Phone Number ____________________ AlternativePhone Number ____________________

Date of Birth ________________ Gender ________ Male ________ Female

Social Security # ______________________________

Name of your physician or clinic ________________________ Phone number ____________________

Are you allergic to bee or wasp stings? _____ yes _____ no

Are you allergic to any foods or medications? If yes, please explain. ______________________________

____

List any dietary restrictions ____

List any activities in which you should not participate ______________________________

Do you have a health condition such as a chronic illness or a special circumstance that we should know about because it may impact your ability to participate in this camp program? If yes, please describe in detail. ________________

____

Should the unforeseen occur, who would you like us to notify in an emergency?

Name ______________________________ Relationship ______________________________

Address ____

Preferred Phone Number ______________________________

Alternative Phone Number ______________________________

ACKNOWLEDGEMENT AND AUTHORIZATION FOR MEDICAL TREATMENT

The information on this form is correct and complete so far as I know, and I am able to engage in all prescribed "50's More or Less" Camp activities, except as noted by me.

About the health services at The Phoebe Needles Center

1. In case of emergency, we will call the local EMS service. It takes at least 10 minutes for an ambulance to get to camp.
2. Our camp does have an AED at camp.
3. Our camp does not have portable oxygen at camp.
4. Adult participants manage their own medications; please bring what you anticipate needing.
5. There is a clinic and pharmacy available in Ferrum, 7 miles from camp, and a hospital and pharmacy in Rocky Mount, 12 miles from camp.

Statement of Agreement

I have read the information both on this page and in what was sent to me as an adult participant for this camp program. I understand my health responsibility for managing my health status while at camp. I agree to inform the camp of any changes that might impact my participation.

I understand that there is a certain degree of risk and possible injury by reason of the program and its activities. I hereby give my permission to the staff of the Phoebe Needle Center, Inc. to provide routine health care, administer prescribed medications and seek emergency medical treatment, including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give my permission to the Phoebe Needles Center, Inc. to arrange necessary related transportation for me. In the event the person listed herein cannot be reached in an emergency, I hereby give my permission to the physician selected by the Phoebe Needles Center, Inc. to secure and administer treatment, including hospitalization, for the above named person. This completed form may be photocopied for trips off the Phoebe Needles Center, Inc. property.

Signature ______________________________

Print Name ______________________________

Date ______________________________

PLEASE RETURN ALL MATERIALS TO:

The Phoebe Needles Center
732 Turners Creek Road
Callaway, Virginia 24067-5814
(540) 483-1518 (800) 848-1677
Fax (540) 483-2235 Email PNCenter@gmail.com

Name ______________________________

Camp Session ______________________________

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