Emergency Contact Information

Aquehongian Lodge 112 **Brotherhood Saturday**

September 21, 2002 at Pouch Camp

Participant's Name________________________________ Date of Birth_________ Age_____
Name of Parent/Guardian or next of kin____
Phone (___)___________ Additional phone numbers (___)____________ (___)__________
Home Address_____________________________ City____________ST______ Zip_________
Business Address___________________________City____________ST_______Zip________

If person above is not available in the case of an emergency, contact (list two)
Name__________________________ Relationship ______________Phone_(__)_______
Name__________________________ Relationship ______________Phone_(__)_______
Name of Personal Physician____________________________ Phone_(___)___________
Personal Health/Accident Insurance Carrier__________________Policy #____________

In case of an emergency, I understand every effort will be made to contact me (parent, guardian or next of kin). If I cannot be reached, I hereby give my permission to the physician selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medications for my child (or me, if an adult).

Date ___/____/___ Parent's Full Name (print) _______________________________

Signature of Parent/Guardian or adult_______________________________________

Check all items that apply, past or present, to your health history, Explain any "YES" answers.

Allergies, any and all Yes___ No___ List: ____
____

General Medical Information: Circle Yes or No

Asthma	Yes	No	**Diabetes**	Yes	No
Cancer/ Leukemia	Yes	No	**Heart Trouble**	Yes	No
Convulsions/Seizures	Yes	No	**Hemophilia**	Yes	No
High Blood Pressure	Yes	No	**Kidney Disease**	Yes	No

Other (list) ____
List medications/dosage to be taken at camp ___________________________________
List any physical or behavioral conditions that may affect or limit full participation in all activities (if none, state none) ____
____
List equipment used by participant (such as wheel chair, braces, glasses, contact lenses, etc.)
____

Please give last immunization date of Tetanus Toxoid ____/____/____

This form must accompany all Youths and Adults who are participating in the event!