



The Episcopal Diocese
of Hawaii

Medical Questionnaire and Treatment
Authorization Form

Accident and illness coverage is the responsibility of the parent/guardian or participant. The following information is needed for participation of **all persons** attending God Camp. This form effective for the year 2010.

PARICIPANT INFORMATION

Name	Age	Entering Grade	Date of Birth	M/F
Parent(s) /Guardian(s) Name	Day/Business Phone		Evening Phone	
1.				
2.				
Home Address	City	State	Zip code	

EMERGENCY CONTACT: In an emergency please notify the following person of the parent or guardian cannot be reached

Name	Relationship to Participant	Phone	
Address	City	State	Zip code

MEDICAL INSURANCE INFORMATION

Medical insurance Carrier _____	Group Number: _____
Policy No _____	Membership No _____

MEDICAL HISTORY

Physicians Name		Phone	
Check if child has or has had any of the following conditions			
Anemia	Heart Trouble	Fainting	Homesickness
Diabetes	Kidney Trouble	Sleepwalking	Other please explain
Dyslexia	Seizures	Bedwetting	
Any Allergies		Dietary Needs	

MEDICAL INSTRUCTIONS

All medication, prescription or non-prescription, must be left in the original container as required by law and turned over to the Camp Director, and will be administered by them. Please list medications to be given, dosage, and frequency below.

Medical Condition	Medication	Dosage	Frequency / when taken
1.			
2.			
3.			

