(page 1 of 1) This is the only health form adult campers need Mail at least two weeks prior to event or bring it with you to: Pilgrim Lodge ~ Health Form 103 Pilgrim Lodge Lane West Gardiner, ME 04345 Image 1 min adult campers: you can mail this in, bring it with you of fill one out at camp. Thank you. Camper Home Address:			
(page 1 of 1) This is the only health form adult campers need Mail at least two weeks prior to event or bring it with you to: Different campers: you can mail this in, bring it with you of file one out at camp. Thank you. Pilgrim Lodge - Health Form 103 Pilgrim Lodge Lane West Gardiner, ME 04345 For adult campers: you can mail this in, bring it with you of file one out at camp. Thank you. Camper Home Address:		Dates attending camp: from to	
This is the only health form adult campers need Image:		Camper Name:	
Bigrim Lodge - Health Form 103 Pilgrim Lodge Lane West Gardiner, ME 04345 fill one out at camp. Thank you. fill one out at camp. Thank you. Camper Home Address:	(page 1 of 1) This is the only health form adult campers need	□ Male □ Female Date of Birth	
West Gardiner, ME 04345 Camper Home Address:	Pilgrim Lodge - Health Form	For adult campers: you can mail this in, bring it with you or fill one out at camp. Thank you.	
Person to contact in case of emergency: Name: Relationship Preferred to Camper Phones (e e		
Person to contact in case of emergency: Name: Relationship Preferred to Camper Phones (Camp	
Person to contact in case of emergency: Name: Relationship Preferred to Camper Phones (Camper Home Address:Street Address	City State Zip Code	
Relationship Preferred to Camper	Person to contact in case of emergency:		
to Camper			
(if different from above) Allergies: No known allergies I am is allergic to: Food Medicine Environmental agents (insect stings, hay fever, etc.) (please describe below what you are allergic to and the reaction seen.) Diet, Nutrition: I eat a regular diet. I eat a regular vegetarian diet. I have special food needs (Please describe below, continue on back if necessary) I have reviewed the program and activities of the camp and feel I can participate without restrictions I have reviewed the program and activities of the camp and feel I can participate with the following restrictions or adaptations (Please describe, continue on back if necessary.) Medical Insurance Information: I am covered by medical/hospital insurance Yes No Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable. Insurance Company Subscriber Insurance Co. Phone No. (), ()	
Allergies: No known allergies I am is allergic to: Food Medicine Environmental agents (insect stings, hay fever, etc.) (please describe below what you are allergic to and the reaction seen.) Diet, Nutrition: I eat a regular diet. I eat a regular vegetarian diet. I have special food needs (Please describe below, continue on back if necessary) I have reviewed the program and activities of the camp and feel I can participate without restrictions I have reviewed the program and activities of the camp and feel I can participate with the following restrictions or adaptations (Please describe, continue on back if necessary.) Medical Insurance Information: I am covered by medical/hospital insurance Yes No Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable. Insurance Company Subscriber Insurance Co. Phone No. ()			
Diet, Nutrition: l eat a regular diet. l eat a regular vegetarian diet. have special food needs (Please describe below, continue on back if necessary) have reviewed the program and activities of the camp and feel I can participate without restrictions have reviewed the program and activities of the camp and feel I can participate with the following restrictions or adaptations (Please describe, continue on back if necessary.) Medical Insurance Information: I am covered by medical/hospital insurance Yes No Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable. Insurance Company Policy Number Subscriber	Allergies: No known allergies I am is allergic to: Food Medicine Environmental agents (insect stings, hay fever, etc.)		
I have special food needs (Please describe below, continue on back if necessary) I have reviewed the program and activities of the camp and feel I can participate without restrictions I have reviewed the program and activities of the camp and feel I can participate with the following restrictions or adaptations (Please describe, continue on back if necessary.) Medical Insurance Information: I am covered by medical/hospital insurance Information is readable. Insurance Company Policy Number Subscriber Insurance Company Policy Number Policy Number Policy Number Insurance card if appropriate; copy both sides of the card so information is readable. Insurance Company Policy Number Policy Number Insurance Co. Phone No. () Insurance for Health Care: I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medica- totos necessary for treatment, referral, billing, or insurance purposes. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives of the purposes of the camp persentatives related to the preson or uprude relevant information to the camp presentatives related to the person's ability to participate in camp activities. In the event I cannot communicate in an emergency, hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp. Date:	(please describe belo	ow what you are allergic to and the reaction seen.)	
I have special food needs (Please describe below, continue on back if necessary) I have reviewed the program and activities of the camp and feel I can participate without restrictions I have reviewed the program and activities of the camp and feel I can participate with the following restrictions or adaptations (Please describe, continue on back if necessary.) Medical Insurance Information: I am covered by medical/hospital insurance Information is readable. Insurance Company Policy Number Subscriber Insurance Company Policy Number Policy Number Policy Number Insurance card if appropriate; copy both sides of the card so information is readable. Insurance Company Policy Number Policy Number Insurance Co. Phone No. () Insurance for Health Care: I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medica- totos necessary for treatment, referral, billing, or insurance purposes. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives of the purposes of the camp persentatives related to the preson or uprude relevant information to the camp presentatives related to the person's ability to participate in camp activities. In the event I cannot communicate in an emergency, hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp. Date:			
☐ 1 have reviewed the program and activities of the camp and feel I can participate without restrictions ☐ have reviewed the program and activities of the camp and feel I can participate with the following restrictions or adaptations (Please describe, continue on back if necessary.) Medical Insurance Information: I am covered by medical/hospital insurance ☐ Yes ☐ No Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable. Insurance Company Policy Number Subscriber			
☐ I have reviewed the program and activities of the camp and feel I can participate with the following restrictions or adaptations (Please describe, continue on back if necessary.) Medical Insurance Information: I am covered by medical/hospital insurance ☐ Yes ☐ No Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable. Insurance Company Policy Number	I have special food needs (Please describe below	w, continue on back if necessary)	
☐ I have reviewed the program and activities of the camp and feel I can participate with the following restrictions or adaptations (Please describe, continue on back if necessary.) Medical Insurance Information: I am covered by medical/hospital insurance ☐ Yes ☐ No Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable. Insurance Company Policy Number			
Medical Insurance Information: I am covered by medical/hospital insurance Yes No Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable. Insurance Company Policy Number Insurance Company Policy Number	I have reviewed the program and activities of the camp and feel I can participate with the following restrictions or adaptations		
Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable. Insurance Company Policy Number Subscriber Insurance Co. Phone No. () Authorization for Health Care: Insurance Co. Phone No. () Authorization for Health Care: Insurance Co. Phone No. () Comparison to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for me, as may be necessary, including, but not limited to Xrays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR § 164.510(b)) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: I) to provide relevant information to the camp representatives related to the person's ability to participate in camp activities. In the event I cannot communicate in an emergency, hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.	(Please describe, continue on back if necessary.)		
Insurance Company			
Subscriber Insurance Co. Phone No. () Authorization for Health Care: I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for me, as may be necessary, including, but not limited to Xrays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR § 164.510(b)) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: I) to provide relevant information to the camp representatives related to the person's ability to participate in camp activities. In the event I cannot communicate in an emergency, hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.			
Authorization for Health Care: I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for me, as may be necessary, including, but not limited to Xrays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR § 164.510(b)) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: I) to provide relevant information to the camp representatives related to the person's ability to participate in camp activities. In the event I cannot communicate in an emergency, hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.			
I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medica- tions, and emergency treatment for me, as may be necessary, including, but not limited to Xrays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any re- cords necessary for treatment, referral, billing, or insurance purposes. Further, it is my intention that the appropriate represen- tatives of the camp be treated as "personal representatives" for the purposes of disclosing protected health information pursu- ant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR § 164.510(b)) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: I) to provide relevant information to the camp representatives related to the person's ability to participate in camp activities. In the event I cannot communicate in an emergency, hereby give permission to the phy- sician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.	Subscriber Insurance Co. Phone No. ()		
tions, and emergency treatment for me, as may be necessary, including, but not limited to Xrays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any re- cords necessary for treatment, referral, billing, or insurance purposes. Further, it is my intention that the appropriate represen- tatives of the camp be treated as "personal representatives" for the purposes of disclosing protected health information pursu- ant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR § 164.510(b)) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: I) to provide relevant information to the camp representatives related to the person's ability to participate in camp activities. In the event I cannot communicate in an emergency, hereby give permission to the phy- sician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp. <u>Signature of Adult</u> <u>Camper</u>			
Signature of Adult Date:	tions, and emergency treatment for me, as may be necessary, including, but not limited to Xrays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any re- cords necessary for treatment, referral, billing, or insurance purposes. Further, it is my intention that the appropriate represen- tatives of the camp be treated as "personal representatives" for the purposes of disclosing protected health information pursu- ant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR § 164.510(b)) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: I) to provide relevant information to the camp representatives related to the person's ability to participate in camp activities. In the event I cannot communicate in an emergency, hereby give permission to the phy-		
Camper Date:	sician selected by the camp to secure and administer treatme completed form may be photocopied for trips out of camp.	ent, including hospitalization, for the person named above. This	
If for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance. Page 1/1		Date:	
	If for religious or other reasons you cannot sign this, contact the camp fo	or a legal waiver which must be signed for attendance. Page 1/1	
Check this box and use the other side of this sheet to record any additional information that camp staff should know, or should share with a doctor in the event you are unable to communicate			