CALIFORNIA UNIVERSITY OF PENNSYLVANIA
STUDENT HEALTH SERVICES DEPARTMENT

ADULT HEALTH/EMERGENCY INFORMATION FORM FOR PERSONS ATTENDING CAMP OR CONFERENCE.

CAMP/CONFERENCE:_____ DATE(S) ATTENDING:_____

NAME:_____ AGE:_____
(LAST) (FIRST) (MI)

HOME ADDRESS:_____
(STREET) (CITY) (STATE) (ZIP)

HOME PHONE :( )_____ Cell/ Business Phone :( )_____

IN CASE OF ACCIDENT OR MEDICAL EMERGENCY CONTACT:

NAME:_____ ADDRESS:_____

_____
(CITY) (STATE) (ZIP)

RELATIONSHIP:_____ PHONE/(CELL):(___)_____

HEALTH HISTORY ***(Please check yes or no)***

BLEEDING/CLOTTING DISORDER	**yes___no___**	**LUNG/ASTHMA**	**yes__no__**
DIABETES	**yes___no___**	**PHYSICAL LIMITATIONS**	**yes__no__**
HEARING/VISION IMPAIRMENT	**yes___no___**	**SEIZURE DISORDER**	**yes__no__**
HEART DISEASE	**yes__ no___**	**STROKE**	**yes__no__**
HYPERTENSION	**yes___no___**	**SURGERY**	**yes__no__**
KIDNEY DISEASE	**yes___no___**	**OTHER_____**	

COMMENTS:
DATE OF LAST TETANUS INJECTION: _____

LIST ALLERGIES: _____

LIST MEDICATION YOU ARE TAKING: _____

INSURANCE INFORMATION:

_____ _____
NAME OF CARRIER POLICY NUMBER

I, _____, UNDERSTAND THAT CALIFORNIA UNIVERSITY OF PENNSYLVANIA DOES NOT PROVIDE HEALTH AND ACCIDENT INSURANCE TO STUDENT OR CAMP PARTCIPANTS AND THAT MY INSURANCE IS MY PRIMARY COVERAGE. I ALSO AGREE TO ASSUME FULL RESPONSIBILITY FOR ANY COSTS INCURRED AS RESULT OF ANY EMERGENCY SERVICES AND/ OR TREATMENT.

Signature_____ Date_____