



## Medical Form

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_

Parent(s)/Guardian Name: (If under 18) \_\_\_\_\_

Parent Cell Number(s): \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Policy/Group Number: \_\_\_\_\_

Alternate Contact Person: \_\_\_\_\_

Emergency Phone Number: \_\_\_\_\_

Name any allergies or medications that cannot be taken?

List all current medications?

Do you currently have any medical concerns?

I understand this form will be used to judge medical attention given in the event of an emergency. I authorize the calling of a doctor for providing necessary medical service as needed. In addition, I realize that photographs and video will be taken throughout camp and that pictures / clips of my youth may be used for future SnL advertisement purposes.

\_\_\_\_\_  
Parent/Guardian Signature  
Required for those under eighteen

\_\_\_\_\_  
Participant's Signature  
Required for those who are eighteen