

TEXAS ASTHMA CAMP FOR KIDS  
**STAFF** MEDICAL INFORMATION FORM

Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Pager \_\_\_\_\_

**Emergency Contact**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Pager \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Alternate Emergency Contact**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Pager \_\_\_\_\_ Cell Phone \_\_\_\_\_

Medical Insurance: \_\_\_\_\_

**HEALTH INFORMATION**

Name of Physician: \_\_\_\_\_

Office/Clinic Name: \_\_\_\_\_

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

Phone Number (include area code): \_\_\_\_\_

Please list any medications you are currently taking:

REASON	DRUG	DOSAGE	FREQUENCY
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Brief Medical History (e.g. kidney problems, ear infections, etc.):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medical Information Form - Staff cont.**

List any known reactions to drugs, animals, insects, etc.:

---

---

---

List any known allergies:

---

---

---

Date of last Tetanus Booster: \_\_\_\_\_

Date of last Physical Exam: \_\_\_\_\_

Comments: \_\_\_\_\_

---

---

I hereby verify that all the information stated on both sides of this medical form is correct and reflects all information of which I am aware. I hereby give permission to the medical personnel selected by the Camp Director to provide routine health care; to administer medications; to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me. I hereby give permission to the physician selected by the Camp Director to secure and administer treatment, including hospitalization, for me. In case of an accident or illness, the cost of medical care is the financial responsibility of the ill or injured person. In addition, I hereby give permission for the Texas Asthma Camp for Kids to administer appropriate over-the-counter medications if the nurse deems it necessary. Dosages will be administered according to directions on the bottle unless the physician directs otherwise.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_