Name _____

MEDICAL INSURANCE

INSURANCE INFORMATION (Do not send copy of insurance card with application.)

Name of Insurance Company _____

Policy No. _____

Insurance Company Telephone_____Insurance ID#_____

Name of Insured_____Relationship to Camper_____

TO BE COMPLETED BY CAMPER'S PRIMARY CARE LICENSED PHYSICIAN OR NURSE.

VISUAL ACUITY (Required)

Corrected with glasses Left 20/_____ Right 20/ _____

If either of the camper's eyes are better than 20/200 with glasses, why are they considered legally blind?

_____

IMMUNIZATION (Required)

Wewoka Woods urges each camper to make sure that all immunizations are up to date. Campers **MUST** have had a **tetanus shot** within the past 10 years.

Last tetanus booster date _____

OVER-THE-COUNTER MEDICATIONS

Are there any **over-the-counter medications** the camper cannot take? If so, please list. _____

_____

MEDICAL EXAMINATION (Required)

This examination should be performed not more than 12 months before arrival at camp for determining fitness to engage in strenuous activities.

Height_____Weight_____Blood pressure _____

Diagnosis_____

List Restrictions (if any) _____

I have examined the person herein described and have reviewed their health history. It is my opinion that they are physically able to engage in camp activities, except as noted above.

Licensed Primary Care Medical Professional _____
Signature

Printed name_____ Title _____

Address _____
Number & Street City State ZIP

Phone_____ Date _____