HEALTH FORM

Blue Ridge Outdoor Education Center
237 Camp Mikell Ct.
Toccoa, GA 30577

Phone: (706) 886 - 7621
Fax: (706) 886 - 7580

School/Group:___________________________________
Dates of Attendance:______________________________

General Information:

Participants Name: ____Gender: _________
Date of Birth:___/___/___

Home Address:
____

Parent/Guardian: ________________________
Home Phone: _______________Daytime Phone (if different): _____________

Emergency Contact: ____
Phone Number(s): _______________________

Medical History and Related Information: Please list all medical conditions, medications, allergies, and restrictions to activity along with an explanation. Use back/additional sheets as necessary.

Insurance Information:

Is the participant covered by an insurance plan? Yes __ No __ Carrier/Plan name:_______________________

Group Number: ____________________________________ Name of Insured: __________________________

Carrier Address: ______________________________________

Social Security Number of policyholder or insurance ID number: ____________________________________

Permission to Provide Necessary Treatment or Emergency Care: I hereby give permission to the medical personnel selected by Blue Ridge Outdoor Education Center to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child. In the event of an emergency and an effort to reach me fails, I hereby give permission to the physician selected to secure and administer treatment, including hospitalization, for the participant named above.

Signature of parent/guardian: ____ Date: __________________
(The signature above acknowledges the permission to provide necessary treatment and acknowledgment of risk)