



**CAMP RAMAH IN CALIFORNIA, INC. (805) 646-4301**  
**EMERGENCY MEDICAL CARD - STAFF (18 AND OVER)**  
 PLEASE TYPE OR PRINT CLEARLY (WITH A PEN)

**STAFF MEMBER'S INFORMATION**

Name: (last, first)		Sex: M F	Social Security #
Address: St. No. & Name	City	ST	Zip
Date of Birth: Mo/Day/Yr	Cell Phone #	Home Phone #	

**STAFF MEMBER'S AGREEMENT, MEDICAL AUTHORIZATION, AND HEALTH INSURANCE INFORMATION**

*Please read carefully and sign below*

In case of emergency, I hereby give permission to the Camp Director or his representative to authorize the administration of health care service to me by a physician or other professional health care provider (hospital, paramedic, nurse, etc.). I also give my permission to the physician selected by the Camp Director to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for me. I understand that Camp Ramah assumes no responsibility for the payment, adequacy or quality of service rendered by the physician or other health care providers selected in such an emergency. I also give my permission to the physician or camp personnel selected by the Director to advise or treat me for any illnesses or medical condition while I am at camp. *\*This completed form may be photocopied for trips out of camp.*

Liability limits of Camp Ramah's insurance: In case of illness or accident, all claims must be filed initially with my individual insurance carrier. The camp's insurance may cover deductibles and other amounts not covered by my private insurance carrier up to a limit of \$1,000. In the absence of insurance coverage, I accept responsibility for medical costs. I accept all responsibility for costs of medications prescribed, dental and orthodontic treatments. I authorize the camp to deal directly with my health insurance as stated below:

Name of Insurance Co.: \_\_\_\_\_ Policy # \_\_\_\_\_

Address of Insurance Co.: \_\_\_\_\_ Phone # \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Subscriber's Name \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION (Person to contact in case of emergency)**

Name:		Relationship:			
Home:	Fax:	Work :	Cell:	Pager:	
( )	( )	( )	( )	( )	

**HEALTH HISTORY**

**MEDICATIONS BEING TAKEN** Please list all medications (prescription and non-prescription) that your child takes on a routine basis.

Medication	Dosage	Specific Times Taken Daily	Reason For Taking

*Have you been hospitalized? When? For what reason?*

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Check any of the following you have/had?

- |  |  |   |                                      |
|--|--|---|--------------------------------------|
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Penicillin Allergy       | <input type="checkbox"/> Seizures    |
| <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Injuries            | <input type="checkbox"/> Poison Oak Allergy       | <input type="checkbox"/> Surgery     |
| <input type="checkbox"/> Ear Infections (frequent) | <input type="checkbox"/> Insect Bite Allergy | <input type="checkbox"/> Psychotherapy/Counseling | <input type="checkbox"/> T.B         |
| <input type="checkbox"/> Hay Fever                 | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Rheumatic Fever          | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Heart Disease             |  |   |                                      |

Please explain any items checked:

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- Allergy to other medication. Please specify \_\_\_\_\_ What is Reaction? \_\_\_\_\_
- Food Allergies - Which Foods? \_\_\_\_\_

Name of Regular Physician	Office Phone Number ( )
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