



GLLM Adult Retreat Guest Health Information

Legal Name _____ Last _____ First _____ MI _____

Birth Date ____ / ____ / _____

Emergency Contact Information

1st Emergency Contact _____ Relationship _____

Home Phone _____ Work Phone _____ Cell Phone _____

2nd Emergency Contact _____ Relationship _____

Home Phone _____ Work Phone _____ Cell Phone _____

Do you have any dietary restrictions? Please explain:

****Please call us 2 weeks prior to your visit so we can prepare to accommodate your dietary needs.***

Do you have any allergies to food, drugs, or other environmental allergens? If so, please list:

Please explain a typical reaction and treatment options:

Do you require an Epi Pen? Y N **If you require an EpiPen, please provide an EpiPen for use while at camp.*

Do you have any restrictions on activity? If so, please explain what activities must be restricted and list any special accommodations that should be made.

Medications: *This information would only be viewed in the event of an emergency.*

Medication Name	Time Taken and Dosage

Important information: For everyone's safety, State Law requires that ALL medications brought to camp must be kept in a locked location. The only exceptions to this rule are Rescue Inhalers and Epi-pens. ALL medications must be in an original pharmacy container with the correct name, date, and instructions on the bottle. Accordingly, Standard Orders for Health Care are provided for the camp by a licensed physician at the New London ACMC. This allows the GLLM to administer first aid and dispense medications.

This health history is correct and accurately reflects my health status. I agree that I am able to engage in all camp activities, except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of this person for both routine health care and in emergency situations. If I cannot be reached or communicated to in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery. I understand the information in this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form if needed.

Signature: _____ Date: _____