

Please contact Teva in advance at (860) 824-3175 or wilderness@tevacenter.org with any food allergies or medical concerns that may require advanced arrangements.

TEVA LEARNING CENTER MEDICAL FORM

Student's Name _____ Date of Birth ___ / ___ / ___ (Age ___)
Last First Middle

School _____ Teacher _____ Grade _____

Address _____

Sex ___ Weight ___ Height ___

Parent or Guardian's Name _____

Home Phone () _____ Alternate Phone () _____

Family Physician _____ Phone () _____

In Case of Emergency, notify the following if a parent cannot be contacted:

Name _____ Relationship _____ Phone () _____

Name _____ Relationship _____ Phone () _____

Home and Health Questionnaire

1. Is this the student's first overnight camp experience? _____

2. The date of the student's last diphtheria-tetanus or tetanus booster is _____ (must be current)

3. List any current activity restrictions or special health concerns (such as recent sprains or fractured bones, recent hospitalizations, special diet, etc.)

4. List allergies (including food, environmental, medication), degree of severity, and treatment.

5. List any chronic or recurring illnesses (ear/throat infections, asthma, diabetes, etc.) and explain.

6. Additional information (including sleep habits, bedwetting)

7. Insurance Information:

Is your child covered by a health or accident insurance policy? Yes ___ No ___

If "yes," name of insured _____ SS # _____
First Middle Last

Address of Insured _____

Name and Address of Insurance Company (address to submit claims)

Name _____ Policy # _____

Address _____ Insurance Agent _____

Phone number of Company () _____ Address _____