THE MASTER'S WORKSHOP CAMP, Inc.

179 Church Camp Lane, Waco, TX 76706
254-662-0441

Camp Staff Emergency Medical Information

Name: First_____Middle _____ Last_____

Age: _____ **D.O.B.** _____/_____/_____ **Gender**: M _____ F _____

Social Security #:_____ **Physical limitations**:_____

_____

Physician:_____ **Location**:_____ **Phone**:_____

In Case of Emergency:

Notify:_____ **Relationship**:_____

Contact Information: **Address**:_____

Home: (_____)_____**Work**: (_____)_____**Cell**: (_____)_____

Notify:_____ **Relationship**:_____

Contact Information: **Address**:_____

Home: (_____)_____**Work**: (_____)_____**Cell**: (_____)_____

Insurance Information:

Are you insured? YES NO **Insurance Carrier Name**:_____

Policy Holder:_____ **Relationship**:_____

Do you have your insurance card with you? YES NO **If NO, continue below:**

Policy Number:_____ **ID/Group Number**:_____

Any Known Allergies:

Please list all allergies: food, medical, nature, etc _____

_____

_____

Additional Information:

Please list any information that the nurse/medical staff may need to know:_____

_____

_____

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