

Applicant Name: \_\_\_\_\_  
Last First Middle



## Staff Medical Information Sheet

**(Either applicant to fill (if over 18) or parent/guardian)**

### APPLICANT INFORMATION

GENDER: \_\_\_ Male \_\_\_ Female    DATE OF BIRTH: \_\_\_\_\_    AGE AT CAMP: \_\_\_\_\_  
STREET \_\_\_\_\_    CITY: \_\_\_\_\_    STATE: \_\_\_\_\_  
ZIP: \_\_\_\_\_    HOME PHONE: \_\_\_\_\_    CELL# (Campers): \_\_\_\_\_

The primary Parent/Guardian for medical questions would be: \_\_\_\_\_

### MOTHER'S/GUARDIAN'S INFORMATION

NAME: \_\_\_\_\_    DAYTIME PHONE: \_\_\_\_\_  
EVENING PHONE: \_\_\_\_\_    CELL PHONE: \_\_\_\_\_  
Email: \_\_\_\_\_    Other#: \_\_\_\_\_

### FATHER'S/GUARDIAN'S INFORMATION

NAME: \_\_\_\_\_    DAYTIME PHONE: \_\_\_\_\_  
EVENING PHONE: \_\_\_\_\_    CELL PHONE: \_\_\_\_\_  
Email: \_\_\_\_\_    Other#: \_\_\_\_\_

### EMERGENCY CONTACT

NAME: \_\_\_\_\_    DAYTIME PHONE: \_\_\_\_\_  
EVENING PHONE: \_\_\_\_\_    CELL PHONE: \_\_\_\_\_  
RELATION: \_\_\_\_\_    Other#: \_\_\_\_\_

### PHYSICIAN INFORMATION

NAME: \_\_\_\_\_    PHONE: \_\_\_\_\_  
ANSWERING SERVICE: \_\_\_\_\_    Date of last exam: \_\_\_\_\_  
Address: \_\_\_\_\_

### DENTIST/ ORTHODONTIST INFORMATION

NAME: \_\_\_\_\_    PHONE: \_\_\_\_\_

### INSURANCE INFORMATION

SUBSCRIBER NAME: \_\_\_\_\_    SOCIAL SECURITY#: \_\_\_\_\_  
CARRIER NAME: \_\_\_\_\_    GROUP NAME \_\_\_\_\_  
CARRIER ADDRESS: \_\_\_\_\_  
GROUP NUMBER: \_\_\_\_\_



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**Parental permission/responsibility declaration (For staff applicants under 18 years)**

I agree that the program may take my child from the premises of the Indira Community Center to attend activities under the supervision of its staff. I grant permission for my child to receive all necessary medical treatment if it is necessary for the proper health care of my child. I also agree to the release of medical information from such doctors, hospitals or other health care agencies where my child has received medical services. I hereby release the Hindu Heritage Summer Camp Inc., its employees and agents from any liability for any accidents or injuries that my child may incur while attending the Camp program. I have reviewed this application and hereby certify that all the information contained in this application is complete and true to the best of my knowledge.

**MEDICAL TREATMENT/EMERGENCY AUTHORIZATION**

This health history is correct so far as I know, and the person listed above has permission to engage in all prescribed camp activities except as noted. I hereby give permission to the camp:

1. To provide ongoing health care.
2. To select medical personnel and to order x-rays or routine tests for treatment for the above.

**EMERGENCY AUTHORIZATION:** In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp medical staff to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for the person named above. I/We agree to assume any expenses for medical care given to our child during his/her stay at Hindu Heritage Summer Camp.

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

Signature(Applicant(over 18)/Parent/Guardian): \_\_\_\_\_

Name of Person whose signature appears above: \_\_\_\_\_

**Please mail completed applications to:**

**Hindu Heritage Summer Camp**  
Dr. Piush Sharma  
2 Da Vinci Drive  
Rochester, NY 14624