

# Nature Camps, Inc.

## Staff Medical Information

Counselor Name: \_\_\_\_\_

Counselor Address: \_\_\_\_\_

\_\_\_\_\_

Name of Health Care Provider: \_\_\_\_\_

Name of Insurance Provider: \_\_\_\_\_

Insurance Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Date of Last Tetanus Shot: \_\_\_\_\_

Significant Medical Problems/History    No \_\_\_\_\_

Yes \_\_\_\_\_, Describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medications at This Time: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I certify that the above information is complete and accurate to the best of my knowledge.

**I also verify that I am drug free.**

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