

**Church of the Covenant Workcamp/Travel
2005 Medical Information Form**

Name _____

Phone () _____

Address _____

City/State/Zip _____

Date of Birth _____

Age _____ Sex _____

Social Security Number_ _____

Family Physician _____

Phone () _____

Family Dentist_ _____

Phone () _____

Medical Insurance Information: **(attach a copy of medical card)**

Name of Parent _____

Phone () _____

Employer _____

Phone () _____

Health Insurance Company_ _____

Policy# _____

Dental Insurance Company_ _____

Policy # _____

Date of last tetanus shot: _____

Date of last hospitalization: _____

Reason: _____

Drug allergies or sensitivities **(especially to penicillin, sulfa, antihistamines, and local anesthetics, such as Novocain):**

Current medication/health concerns **(include drug, dose and frequency):**

Food considerations **(include vegetarian, food sensitivities, and special diet):**