HEART OF THE STORM
P.O. Box 1446
Blue Hill, Maine 04614
207.664.8004
www.heartofthestorm.org christina@heartofthestorm.org

Medical Form

Name: _____ Birth date: _____

Home Address:_____City _____State_____ Zip_____

Mailing Address:_____

Name of Parent/ Guardian:_____

Home Phone: _____ Cell Phone: _____ Work phone: _____

Email:_____

If the above are not available in an emergency, please contact:

Name: _____ Relationship:_____

Phone: _____ Cell Phone: _____ Work phone: _____

Email _____

Insurance information

Is the participant covered by family medical/health insurance? Yes _____ No _____
(Students are not required to have medical insurance to attend HOTS.)
• Please include a photocopy, front and back, of your insurance card and attach it to this medical form.
Please indicate the carrier or plan name: _____
Address and Phone Number of carrier:_____
Insured name: _____ Insurance ID # _____
Permission to Provide Necessary Treatment or Emergency Care:
I hereby give permission to the medical services provider selected by the camp representative to order x-rays, routine tests and treatment; and
to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child or myself. In
the event that I cannot be reached in an emergency, I hereby give permission to the medical services provider selected by HOTS
representative to secure and administer treatment, including hospitalization, for the person named above.
_____ Date _____
Signature of parent or guardian of HOTS participant.

Are there any medical conditions or restrictions, physical or emotional issues that might limit your participation in sailing, hiking, exploring, diving (see Diving Medical Form) and/ or living aboard a sail boat in close proximity to others?
YES _____ NO _____ If YES, please explain: _____

Do you have any special needs: YES _____ NO _____ If yes, please explain:
_____

Please use this space to provide any additional information about yourself:

Name of family physician: _____Phone: _____

Address:_____

Name of family dentist/orthodontist: _____Phone: _____

Address:_____

Date of last tetanus shot: _____
This is especially important in the event of an open wound that needs treatment. Tetanus shots are good for 10 years, unless there is an open wound within 5 to 10 years after the initial immunization. This information could save you from receiving an unnecessary shot.

KNOWN ALLERGIES:

Medical:_____
Food:_____
Insects_____

Do you take any medication, over the counter or prescription, please list below :

Do you have any food preferences:

Is there anything else you would like us to know: