



## ADULT STATISTICAL AND EMERGENCY INFORMATION

MAIL TO THE OFFICE BY MAY 15, 2009

**Ogichi Daa Kwe**  
3515 Michigan Avenue  
Cincinnati, OH 45208  
[www.ogichi.org](http://www.ogichi.org)  
Phone: (513) 772-7479  
Fax (513) 772-5673

(required for Canadian and U.S. Customs and Immigration, fishing licenses, emergencies)

Full Name: \_\_\_\_\_ Maiden Name: \_\_\_\_\_

Permanent Address: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Title: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Business e-mail: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### IN CASE OF EMERGENCY, whom should we call?

Contact Person: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone / Work / Cell: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone / Work / Cell: \_\_\_\_\_

**Please photocopy your PASSPORT in the provided space below:**



## BACKGROUND CHECK & MEDICAL HISTORY INFORMATION

Name: \_\_\_\_\_  
Day Phone: (\_\_\_\_) \_\_\_\_\_  
Cell Phone: (\_\_\_\_) \_\_\_\_\_  
Evening Phone:(\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_

We use this information to: 1. Plan appropriate meals including individual diet needs; 2. Provide healthcare staff with background about your health; 3. Determine eligibility to cross Canadian boarder. Receiving adequate information prior to arrival is crucial to our ability to provide a supportive environment.

### **Background Check**

**This information is necessary for crossing the border into Canada.**

Have you ever been convicted of a crime (DUI, arrests, felony, etc.)?      **Yes**                      **No**

Describe Incident and Date: \_\_\_\_\_

### **Dietary Restrictions/Preferences**

Please check those that apply to you. We will attempt to provide the necessary accommodations to your individual diet needs.

- I eat a regular, varied diet.
- I am lactose-intolerant.
- I am a vegetarian of this type:
  - Semi-vegetarian (no pork or beef)
  - Pesco (no pork, beef, or chicken)
  - Lacto-ovo (no beef, pork, chicken, seafood, or fish)
  - Vegan (no meats, eggs, or dairy)

### **Health Insurance Information**

Company name: \_\_\_\_\_

Subscriber's name: \_\_\_\_\_

Group ID#: \_\_\_\_\_ Member ID#: \_\_\_\_\_

***PLEASE Photocopy the front and back of the card in space provided below or attach to form.***

## Medical History Information Cont.

**Asthma, Diabetes, or Anaphylaxis?**  
Complete additional form available by calling  
(513) 772-7479 or online.

### Allergies: check those that apply

- I have no known allergies
- I have an allergy to the following food, medications, substance(s): \_\_\_\_\_

Does your allergy cause anaphylaxis?                      **Yes**                      **No**

Describe the allergic reaction and what is done to manage it: \_\_\_\_\_

### Medical Conditions

- I have no chronic health concerns and am capable of full participation in this program.
- I have the following chronic health concerns: (Please circle all that apply)

Asthma*	Headaches	Surgical History
Frequent ear infections	Frequent Colds	Skin Conditions
Seizure Disorder	Fractures	Diabetes*
Joint/Muscle Pain	Fainting	Heart Conditions
Menstrual Cramps	Ulcers/GI Complaints	
Other (please describe): _____		

Please provide information about supportive health care needed for each checked item: \_\_\_\_\_

If currently being treated for any of these concerns, please give doctor's name and phone number below:

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name of general practitioner: \_\_\_\_\_ Phone Number: \_\_\_\_\_

### Medications

Please list all prescribed and over the counter medications you take: \_\_\_\_\_

Many medications are stocked at camp and in the health care facility. Please list any medications you **do not** wish to be given: \_\_\_\_\_

**Authorization for Healthcare:** *The health history above is correct to my knowledge. I am physically healthy to participate in physical exertion such as hiking 2 miles carrying weight and paddling a canoe for consecutive hours. In the event that I am unable to communicate, I give permission for the physician selected by Camp Ogichi Daa Kwe to order X-rays, routine tests, treatment, injections, anesthesia, or surgery for me. This form may be photocopied. Camp Ogichi Daa Kwe has permission to obtain a copy of my health record from providers who treat me. I understand that information about my health will be shared on a "need to know" basis with Camp Ogichi Daa Kwe staff.*

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_