

PRIMARY HEALTH CARE PROVIDERS – Please provide the names and phone numbers of your home physicians.

Primary Care _____ Phone _____
Orthodontist _____ Phone _____
Dentist _____ Phone _____
Mental Health Provider _____ Phone _____

WHAT HAVE WE FORGOTTEN TO ASK? Please provide any additional information about your health, which was not discussed on this form. Attach another sheet as necessary.

PAYING FOR HEALTHCARE:

- There is usually no cost for healthcare provided by the camp’s healthcare team (Physician and Registered Nurses), except for medications prescribed for you by the physician at camp. (e.g. Antibiotics for strep throat, etc.)
 - Staff members are financially responsible for healthcare provided by out-of-camp providers such as dentists, X-rays, Emergency Room visits, etc.
 - You are responsible for knowing how to access your health insurance while working at Camp. Bring your insurance ID card with you as well as attaching a photocopy to this form. Obtain pre-authorization for out-of-state use if your insurance requires this. The local hospital is Bridgton Hospital, 10 Hospital Drive, Bridgton, ME 04009. Their phone number is 207-647-6000.
 - **CANADIAN STAFF** – Please note that healthcare in the United States is very different than in Canada. Provincial health care plans are NOT accepted at the local hospitals. For your own financial safety, obtain Travel Health Insurance before you leave for Camp. Blue Cross / Blue Shield is recommended.
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AUTHORIZATION FOR HEALTHCARE

This health history is correct as far as I know. I declare that I am capable of performing the essential functions of my job and that I am able to participate in assigned activities except as noted on this form. I understand my health information will be used by Camp Cedar’s healthcare staff in providing care to me and may be reviewed by the camp directors.

I understand that I am financially responsible for all medications, any medically required examinations or diagnostic tests prescribed for me that are not covered by Worker’s Compensation. I authorize Camp Cedar to release any records necessary for insurance purposes and to obtain my health information from other providers when it pertains to my immediate care.

In the event of an emergency where I am unable to give consent, I hereby give permission to the physician selected by Camp Cedar to hospitalize, secure proper treatment for, and to order injection anesthesia, or surgery for me.

Signature

Date

Printed Name

**PAGE 2 of 2 - Please complete pages 1 & 2 and return to Camp by June 1st.
You should also send or bring the medical form provided by your exchange program.**