Central Indiana Young Marines

2015 Annual Encampment Medical Form

Young Marine Last Name	Young Marine First Name	Young Marine Middle Initial							
Age	Date of Birth	Social Security Number							
Home Street Address									
City	State	Zip Code							
·									
Parent/Guardian, Primary Emergency		Relationship							
☐ Mother ☐ Father ☐ Other ☐ Other ☐ Father ☐ Other ☐ Other ☐ Father ☐ Other ☐ Father ☐ Other ☐ Father ☐ Other ☐ Father ☐ Other ☐ O									
City	State	Zip Code							
Home Phone Number	Cell Phone Number	Work Number							
	TOTAL MAINE								
Alternate Emergency Contact #:	L Name	Relationship							
	Home Street Address								
	nome offect / tautess								
City	State	Zip Code							
Home Phone Number	Cell Phone Number	Work Number							
Home Phone Number	Cell Prione Number	work number							
Alternate Emergency Contact #2	2 Name	Relationship							
	Home Street Address								
City	State	Zip Code							
Home Phone Number	Cell Phone Number	Work Number							
	Medical Insurance Information (Please attach a copy of the front and back of the insurance card)								
Insurance Company Name	Policy Number	Telephone Number							
Family Physician's Name	Preferred Hospital	Physician Telephone Number							
Family Physician's Name	Preferred Hospital	Physician Telephone Number							
	Authorization for Medical Treatme	nt							
PART I: Medical Consent certify that am	Authorization for Medical Treatme the parent, legal guardian, or other person in legal c	nt control of the above identified child and request and authorize that my							
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_____ Date: _____

Parent/Legal Guardian: ____

Central Indiana Young Marines

2015 Annual Encampment Medical Form

For office use only:

Part IV: Medication Administration Record													
		Friday -	9/13/1	3	9	Saturday	- 9/14/	13		Sunday -	9/15/1	L3	Notes
Medication	AM	Noon	PM	Other	AM	Noon	PM	Other	AM	Noon	PM	Other	
	\times	> <									\times		
	$>\!\!<$	><									\times		
	\times	> <									\times		
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Sick Bay Log									
Date	Time In	Time Out	MO Signature						
Complaint:	•								
Treatment:									
Notes:									
Date	Time In	Time Out	MO Signature						
Camanlaint									
	Complaint:								
Treatment:									
Notes:	Time In	Time Out	MO Signature						
Complaint:		•							
Treatment:									
Notes:									
Date	Time In	Time Out	MO Signature						
Commission									
Complaint:									
Treatment:									
Notes:									
Notes:									
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Medical Officer Signatu	ıre:								
Medical Officer Printed	Į.		Date:						
ivieuicai Officei Fffffleu	·		Date.						