

Staff Health Record



Name: _____ Date Of Birth: _____ Sex: _____
Address: _____
Phone: (____) _____ Cell: (____) _____
City: _____ State: _____ Zip: _____ E-mail: _____

1. Indicate if you have had or been immunized against the following:

MMR	<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	Whooping Cough	<input type="checkbox"/>
Meningitis	<input type="checkbox"/>	Hepatitis A/B	<input type="checkbox"/>	Diphtheria	<input type="checkbox"/>

2. Do you have any of the following conditions? If yes, indicate your present status and treatment on the reverse side of this sheet.

Diabetes	Y / N	Asthma	Y / N
Epilepsy	Y / N	Heart Disease	Y / N
Ulcers	Y / N	other	_____

3. Date of last tetanus immunization/booster: _____

4. Do you have any allergies? Y / N What are they? _____

5. Describe any tendencies you have to such conditions as tonsillitis, colds, bronchitis, menstrual difficulties, etc.

6. General Health: Excellent Good Poor

7. Describe any special diets or precautions you must observe.

8. List any medications (prescribed or over the counter) you are taking. _____

9. List any camp activities from which you must be exempt for health reasons. _____

10. Describe any current physical, mental, or psychological conditions requiring medication, treatment, or special restrictions or considerations while at camp. Use reverse side of form if needed. _____

11. Name of family doctor _____ Phone (____) _____

12. Person to contact in case of an emergency _____
Relationship _____ Phone (____) _____ Cell (____) _____

13. Are you covered with health & accident insurance? Y / N By whom? _____

I hereby authorize the qualified camp personnel to give emergency care and determine the need for a doctor's service.

Applicant's Signature _____ Date: _____
(Parent or Guardian if minor)