

STAFF MEDICAL FORM

Name: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

Name and dates of camp session(s) you will be attending:

CAMP	START DATE	END DATE

Person to be notified in case of emergency: \_\_\_\_\_

Phone: \_\_\_\_\_ Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

This person's relationship to you: \_\_\_\_\_

Secondary Person to be notified in case of emergency: \_\_\_\_\_

Phone: \_\_\_\_\_ Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

This person's relationship to you: \_\_\_\_\_

INFORMATION ON FAMILY MEDICAL INSURANCE

Name of Insurance Company: \_\_\_\_\_

Policy or Group I.D. Number: \_\_\_\_\_ Type of coverage: \_\_\_\_\_

PHYSICIAN AND MEDICAL HISTORY

Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Please list all medications you are currently taking (include dosage and frequency): \_\_\_\_\_

Medical history (diabetes, heart problems, asthma, etc....any information that will be helpful in case of emergency):

Do you have any physical limitations? \_\_\_\_\_ Yes \_\_\_\_\_ No If "Yes", please identify: \_\_\_\_\_

Have you had a tetanus immunization in the past 5 years? \_\_\_\_\_ Yes \_\_\_\_\_ No

I have examined this staff person and found him/her to be in satisfactory physical condition and capable of fulfilling the attached job description.

Signature of Physician or Nurse Practitioner: \_\_\_\_\_ Date: \_\_\_\_\_

Phone: \_\_\_\_\_ Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_