

STAFF HEALTH FORM

Name _____ Birth date _____ Social Security # ____ / ____ / ____

Address _____

Street/P O Box

City

State

Zip

Home Phone (_____) _____ Other Phone (_____) _____

Camp Involvement:

Dean Small Group Leader Site Staff Other _____

Dates of Camp _____ Camp Name _____ Event # _____

Local Church _____ Pastor _____

ALLERGIES List all known allergies, including those involving medication, food, insect, asthma, hay fever and other allergies. Please describe reaction and management.

ALLERGY

REACTION AND MANAGEMENT

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MEDICATIONS Please list ALL medications (including over-the-counter or non prescription drugs) taken routinely. Keep medications in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration. Please be advised that all medications must be turned in to the Camp Health Care Provider prior to camper arrival.

NO Medications on a routine basis

| | | |
|--------------------------|--------------|-------------------------------------|
| Med. #1 _____ | Dosage _____ | Specific times taken each day _____ |
| Reason for taking: _____ | | |
| Med. #2 _____ | Dosage _____ | Specific times taken each day _____ |
| Reason for taking: _____ | | |
| Med. #3 _____ | Dosage _____ | Specific times taken each day _____ |
| Reason for taking: _____ | | |

CURRENT HEALTH CONDITIONS Please describe any current health conditions requiring medications, treatment, or special restrictions or considerations while at camp.

PAST MEDICAL HISTORY Please describe past medical treatment, (i.e., surgeries, heart conditions, fainting, seizures, etc.) or other medical concerns
