Camp Kipanga

Staff Health Form

PLEASE PRINT ALL INFORMATION.

Last Name _____ First _____
Address _____
City, State, Zip _____
Date of Birth _____ _____ Male _____ Female

If under the age of 18 years, please list the name of a parent/guardian _____
Home address of parent/guardian (if different than above) _____
Phone number _____ Business phone _____

Emergency Contact 1 Name _____ Emergency Contact 2 Name_____
Home Phone _____ Home Phone _____
Business Phone _____ Business Phone _____
Cell Phone _____ Cell Phone _____

Medical Information
Physicians Name_____ Phone_____
Please list the date (month/year) of your last tetanus shot _____
Please list any allergies (bee stings, food, medication, etc.) _____
Are there any medications or precautions necessary for this allergy? _____
If yes, please list _____
Are you required to take medications or use an inhaler during camp hours? _____
Medical comments – limitations for camp activities (physical, visual, auditory, etc.) _____
_____
Do you require any medication that might impair your ability to perform the essential functions of your position? If so, please indicate and discuss details with the camp health care provider. _____

Current Conditions
Medication(s) taken_____
Appliances Worn (ex. Glasses)_____
Family Medical Insurance_____ Policy#_____
Family Hospitalization Policy_____ Policy#_____

Consent for Emergency Medical Treatment and Medication
-I hereby give consent to a registered nurse to administer without further consent over the counter medication as indicated by a physician or other medication prescribed by a physician.
-In case of emergency I give authority to the Camp staff to obtain emergency treatment for me. In addition I authorize the doctor or hospital to perform any emergency procedure or operation, to give treatment, and to administer anesthetic to me during my employment at Camp.

_____ _____ _____
Print Name Signature Date