

Employee Medical Form

Employee Information

(please print clearly)

Last Name _____ First Name _____

Address _____ City _____

State _____ Zip Code _____ Date of Birth ____/____/____

Employee's Home Phone () _____ - _____

Parent or Legal Guardian (if under 18 yrs.) _____

Guardian's Home Phone () _____ - _____ Guardian's Work Phone () _____ - _____

In Case of Emergency, when none of the above can be reached, please call:

1. Name _____ Home Phone _____

Work Phone _____ Cell Phone _____

Relationship to employee _____

2. Name _____ Home Phone _____

Work Phone _____ Cell Phone _____

Relationship to employee _____

Insurance Information

Employee Medical Insurance Co. _____ Phone _____

Address _____ City _____ State _____ Zip _____

Group Name _____ Identification # _____

Family Doctor's Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

For use by Parent or Legal Guardian if Employee if Under 18 Years of Age.

I hereby request that the following non-prescription medication(s) be administered if necessary at the discretion of the camp nurse: ___Tylenol ___Ibuprofen ___Aspirin ___Benadryl ___Peptobismol ___Sudafed Other: _____

"In case of emergency, I hereby give my permission to the physician which the camp director selects to perform any emergency medical care as may be necessary. I also acknowledge full responsibility for any medical bills for the above named staff member."

Signature of Parent or Guardian (if under 18 yrs.)

_____ Date _____

Health Information

Does the employee have any physical restrictions or special problems? If yes please list directions below:

Has the employee had recent exposure to any contagious disease? ____Yes ____No
Please list any current medication being taken by employee and the reason for each below:

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Health History (Please check all that apply and double check those occurring within past year)

- | | | |
|--|---|--|
| <input type="checkbox"/> Frequent Sore Throats | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Sleep Walking | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Urinary Tract Infection | <input type="checkbox"/> Seizures | <input type="checkbox"/> Asthma Attacks |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Stomach Upests | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Ear Infections |
| <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Measles | <input type="checkbox"/> Skin Rashes |
| <input type="checkbox"/> Ivy, Oak or Sumac Allergy | | |

Other disease or any additional information we should know?

Immunizations (Please give dates of last injections)

MMR ___/___/___	Tuberculin___/___/___	Tetanus___/___/___
Polio Vaccine___/___/___	DPT___/___/___	Hepatitis B. ___/___/___

If applicant is under 18:

“I believe he/she is able to work at camp and participate in all camp activities with the following restrictions and recommendations (if any)”

Parent's Name_____

Parent's Signature_____Date_____

Any restrictions and recommendataions:

Thank You!