

STAFF MEDICAL FORM

(check one) Volunteer Staff OR Paid Staff

Senior Counselor Assistant Counselor Position _____

Nurse Dean Other Site _____

Event Dean _____ Employment Dates _____

Camp Site/Dates _____

Name _____ Home Phone (____) _____

Address _____

City _____ State ____ Zip _____

Local Church _____ District _____

Pastor's Name _____ Phone (____) _____

Email _____ T-Shirt Size _____

MEDICAL INFORMATION

Birth Date ____ / ____ / ____ Age ____ Male ____ Female ____

Height ____ Weight ____ Allergies _____

1. List any medical problems or restrictions _____

2. List medication you are currently taking _____

3. Have you had a tetanus injection within the past 5 years? Yes ____ No ____

4. Date of last physical examination within the past 24 months _____

Health Insurance Company / HMO _____

ID/Policy # _____ Group # _____

Primary Care Physician _____ Phone (____) _____

Emergency Contact: Name _____ Phone (____) _____

(Signature if 18 years of age or older)

____ / ____ / ____
(Date)

IF AGE 17 OR YOUNGER

Your parent/guardian's signature is required below before you are permitted to take part in the camping program.

Parent's / Guardian's Name(s) _____

Address _____

City _____ State _____ Zip _____

Email Address: _____

Father's Employer _____ Work Phone (____) _____

Cell Number (____) _____

Mother's Employer _____ Work Phone (____) _____

Cell Number (____) _____

Emergency Contact: Name _____ Phone (____) _____

Cell Number (____) _____

Address _____

City _____ State _____ Zip _____

Parent's / Guardian's Signature _____ Date ____/____/____