STAFF MEDICAL FORM

(circle 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 _________________

E-mail____ T-Shirt Size ______________________

Local Church ____ District _________________________

Pastor's Name ___________________________________ Phone (_____)____________________

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 ________/______/______