STAFF HEALTH FORM

Name_____Birthdate_____Age_____Sex_____
Last Middle First

Home Phone_____Work phone_____

Address_____
Street/box city state zip

In case of emergency, notify_____Phone_____

Please check Yes or No to the following:

Asthma…… Yes_____No_____ Ear aches……..Yes_____No_____ Tuberculosis…...Yes____No____
Athlete's Foot…… Yes_____No_____ Frequent colds……..Yes_____No_____ Rheumatic fever.Yes____No____
Bronchitis…… Yes_____No_____ Hypertension……Yes_____No_____ Sleepwalking…..Yes____No____
Convulsions/seizures…Yes_____No_____ Heart conditions……Yes_____No_____ Special diet…….Yes____No____
Diabetes……Yes_____No_____ Physical condition…….Yes_____No_____ Stomach aches….Yes____No____
Other recurring illness:_____

Explanations from above_____

Please indicate the following immunizations you have had and when:
Check date reactions if any
TB Test_____

Tetanus_____

Diphtheria_____

Small pox vaccine_____

Polio injection_____

Other_____

Allergic reactions: if applicable, please give reaction and treatment needed:

Insect stings_____Aspirin_____
Penicillin or other drugs_____Hay fever_____
Other_____

Are there any medications or treatments to be given at camp?_____If so, specify:_____

FOR ALL STAFF UNDER 18: FaHoCha Bible Camp cannot administer prescription medications to staff under age 18 without the written instructions and written permission parent, guardians or physician. Please indicate name of medication, dosage frequency and time to be given, plus any other important instructions.

I hereby certify that_____is in good health, free from communicable disease and able to participate in all camp activities. INCASE OF MEDICAL AND OR SURGICAL EMERGENCY or other necessary medical attention, I hereby give permission to the trained medical staff selected by the camp director to hospitalize, secure proper treatment for , and order injection, anesthesia, x-ray, or surgery for my child as named above. I also give permission for the camp nurse to administer the medications indicated.
Parent's/guardians Signature_____date_____

NOTE: Please fill this section out immediately prior to your arrival at camp.
Have you been exposed to any communicable diseases within three weeks prior to camp?_____Yes_____No

If so, please explain_____

Health Insurance Provider and number_____

Signature_____date_____