STAFF MEDICAL INFORMATION

Name ____Age ___________Phone __________________

Address ____

Do you have any medical conditions or illnesses? _________If yes, explain: _____________________

____

Have you been tested for AIDS? ( ) Yes ( ) No

If Yes, did you test positive? ( ) Yes ( ) No

Do you take any medications? _________If yes, list them: _________________________________

____

____

Please list any past medical treatments you have had: _______________________________________

____

____

When, and for what, were you last hospitalized? ____

Do you have any allergies?___________ If yes, explain:

Medication Allergies: ____

Food allergies:____

Other allergies:____

When did you have your last TETANUS shot? _______________________

Have you had Hepatitis B vaccination? _____________________________

What other immunizations have you had? ____

____

Your physician: ____Phone #: _____________________

Address:____

Are you diabetic? YES or NO

How long have you had diabetes? ______________________________

What type of insulin do you use? _______________________________

If done, your most recent Hemoglobin A1c result: __________________

Signature ____ **Date:** __________________

Staff Member

STAFF MEDICAL CONSENT

In the event of a medical emergency, illness or injury, if I am not competent at that time to make my own decisions, I hereby request and authorize the Camp Medical Director and/or other physicians or medical staff he/she may designate or consult to provide to me emergency medical and/or surgical treatment and/or hospitalization as deemed necessary.

If such a situation occurs, please notify:

Name: ____

Phone #: ____

Address: ____

____

Signature: ____
Staff Member

Staff Member's Name: _____________________________________

Phone Number: ____

Address: ____

____

Date Signed:________________________

STAFF PHYSICAL EXAMINATION

Each staff person must have the following physical examination within six months prior to entering Camp Hickory Hill.

Name: ____Date ____________

Weight: ___________Height: _____________Temp.: __________BP: ___________

Is there any evidence of eye disease or impaired vision? ______________________

Describe* ____

Is there any evidence of illness or communicable disease? ____________________

Describe* ____

Is there any evidence of emotional problems? ______________________________

Describe* ____

Is there any evidence of problems of mobility? ______________________________

Describe* ____

Is there any evidence of heart or lung disease? _____________________________

Describe* ____

Other physical abnormalities? ____

Describe* ____

In my opinion, the above named individual is capable of participating in an active camp
program with the following exceptions: ____________________________________

____

____

*Include medications, other treatments and limitations.

Signature ______________________________, M.D./D.O. Date ____________

Address:____Phone:_______________

____