



June 13-18  
2010  
Deadline May 20

Office Use

**STAFF HEALTH FORM  
INSURANCE INFORMATION**

NAME: \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: (\_\_\_\_\_) \_\_\_\_\_ WORK: (\_\_\_\_\_) \_\_\_\_\_

**INSURANCE POLICY**

Name of Policy Holder: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Policy/Group # \_\_\_\_\_

Type of Coverage: \_\_\_\_\_

Please include a copy of your insurance card

Doctor's Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

**ALLERGIES:** (Please check all that applies)

\_\_\_\_ Bee Sting    \_\_\_\_ Poison Ivy    \_\_\_\_ Penicillin    \_\_\_\_ Poison Oak  
\_\_\_\_ Sumac    \_\_\_\_ Dust    \_\_\_\_ Other (please list and explain) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any special dietary requirements and/or restrictions:

\_\_\_\_\_

Last date of your Tetanus shot? \_\_\_\_\_

Please list any restrictions or limitations we should know about.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PLEASE CHECK ALL THAT APPLIES TO YOU**

\_\_\_\_ Asthma    \_\_\_\_ Diabetic    \_\_\_\_ Takes cold easily    \_\_\_\_ Sunburns easily

**Medication or Insulin**

Dose	Directions	Total Pills	Nurse
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**IN CASE OF AN EMERGENCY NOTIFY:**

NAME: \_\_\_\_\_

PHONE: (\_\_\_\_\_)\_\_\_\_\_ OTHER: (\_\_\_\_\_)\_\_\_\_\_

**AUTHORIZATION FOR EMERGENCY MEDICAL CARE**

I, \_\_\_\_\_ hereby give my permission to camp officials to call a doctor or emergency medical service and for the doctor, hospital or medical service to provide medical, to order injection, anesthesia or surgical care should an emergency arise. It is understood that camp officials will make a conscientious effort to locate the emergency contacts listed above before any action will be taken. If it is not possible to locate emergency contacts listed, I accept the expense of emergency medical or surgical treatment.

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

2/2010