STAFF MEDICAL FORM

Staff Person's Name: ____

Health Card Number: ____

Family Doctor: ____

Family Doctor's Address: ____

Postal Code ____________ **Telephone** _____________________

E-Mail Address (optional)____

Please Complete the Following **(please print)**

Are you immunized? (Please check)
Tetanus____ Date: ___________ Polio ____ Date: ____________
MMR _____ Date: ____________ Diphtheria ___ Date: ____________

Allergies? Bee, wasp or hornet sting ___ Penicillin ___ Other drugs ___ Animals ___
Foods (Please List)

____

Do you carry ANA kit: yes __ no __ Carry Epipen: yes __ no __

Describe any physical or emotional characteristics that may be useful knowledge for the camp health care staff:

____

Describe any treatments or special medications to be given at camp:

____

____

____

List any restrictions to camp activities:

____

To the best of my knowledge I am in good health and able to participate in all camp activities. (Please sign below)

____