Staff Medical Form

Revised 3.30.22

Both sides must be completed by staff member for participation at camp.
Give this form to the Health Officer prior to camp. Please PRINT CLEARLY using a pen.

Camp Brethren Heights, 9478 Brethren Heights Rd., Rodney, MI 49342.

Staff Information

Last Name: ____________________________ **First Name:** ____________________ **M.I.**________

Name you prefer: ______________________ **Birth Date:** _____________________**Email:** ___________________

Mailing Address: ____

Insurance Information: *Are you covered by health insurance?* **Y / N**

Insurance Company: ____

Policy/Group Number:____

Emergency Contacts

Emergency contact name: __________________________________

Home phone: ________________________________ **Work phone:** ______________________________________

Cell: __________________________________

Who to call if emergency contact is not available: __________________________ **Relation:** ________________

Home phone: ___________________ **Work phone:** ___________________ **Cell phone:** ____________________

Health History

Family Physician: _____________________________________ **Phone:** ____________________________________

If you answer yes below, please explain on a separate sheet or in comment section below.

Have/do you:

1. Had any recent injury, illness or disease?	**Y / N**	9. Had mononucleosis in the past 12 months?	**Y / N**
2. Have a chronic or recurring illness/condition?	**Y / N**	10. Ever had frequent ear infections?	**Y / N**
3. Ever been hospitalized?	**Y / N**	11. Have a bleeding or clotting disorder?	**Y / N**
4. Have frequent headaches?	**Y / N**	12. Ever been diagnosed with a heart defect/disease?	**Y / N**
5. Ever had a seizure?	**Y / N**	13. Wear glasses, contacts or protective eyewear?	**Y / N**
6. Have diabetes?	**Y / N**	14. Brought an orthodontic appliance to camp?	**Y / N**
7. Have asthma?	**Y / N**	15. Have problems with sleepwalking?	**Y / N**
8. Ever had high blood pressure?	**Y / N**	16. Ever been treated for emotional difficulties?	**Y / N**

Allergies

Please list any allergies you may have (*medications, insect stings, food or other***):** _________________________

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Restrictions

The following restrictions apply to me; *(attach additional paper if needed)***:**

Dietary:____

Explain any restrictions to activity (*what* ***cannot*** *be done; what* ***adaptations or limitations*** *are necessary***):**

____

____

Medications

☐ I will ***not*** be bringing any medication (prescription or non-prescription) to camp.

☐ I will be bringing the following medication (prescription or non-prescription) **in its original container labeled with my name**. *Please list the medications below, use additional paper if needed.*

Medication(s): Dosage: Time: Reason for taking medication:

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Anything else you would like our staff to know? ______________________________

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STAFF AUTHORIZATIONS:

The personal and medical information is correct and complete as far as I know. I give permission to the camp to provide routine health care, administer prescribed and OTC medications, and seek emergency medical treatment including ordering X-rays, routine tests and treatment. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for me. I give permission to the physician/health officer selected by the camp to secure and administer treatment, including hospitalization if need be. This completed form may be photocopied for off-site camps.

Staff Member Signature: ________________________________ **Date:** ____________

Printed name: ______________________________

The information on this form is kept in strict confidence by Camp Brethren Heights directors & health officers.
Complete both sides of this form; keep a copy for your records. This form may be photocopied.
Printable forms and all program information are available at **www.campbrethrenheights.org** *or call us at (231) 867-3618.*