CAMP AHAVA

Staff Health History Form

Name____
Last First M.I.

Date of Birth ____Age _____________Sex________

Home Address____
Street Number City State Zip

Home Phone Number _______________________________ Cell Phone________________________

Mother's work number ________________________ Cell Phone______________________________

Father's work number ________________________ Cell Phone_____________________________

#1. Emergency Contact_________________________ Phone ______________________________

#2. Emergency Contact____________________________________Phone _______________________

Name of Family Physician ______________________________Phone _________________________

Date of last physical checkup _______________________

Do you carry family medical/hospital insurance? _________ yes _________no

If so, indicate, Carrier_____________________Group or Policy #____________________________

Health Carrier phone number: ____

Health History (check all that apply)

_____Frequent Ear infections
_____Seizures/Convulsions
_____Bleeding/Clotting Disorders
_____Mononucleosis
_____Heart Defect/Disease
_____Diabetes
_____Hypertension
_____Psychiatric Treatment

Are you taking medication? ____No _____Yes; If so, what medication, including dosage and for what condition?____

____

Diseases (check all that apply including dates)

____________Chicken Pox
____________German Measles
___________Measles
___________Mumps

Date of Last Tetanus Shot_____________

Allergies (check all that apply)

_____Hay Fever
_____Insect Stings
_____Other Drugs
_____Foods (please specify)________________
_____Bee Stings
_____Penicillin
_____Asthma
Other___________________________

Important – This Section Must be Completed for Attendance:

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted. Authorization for Treatment: I hereby give permission to the medical personnel selected by the camp Associate Director & Staff to order x-rays, routine tests, treatment and necessary transportation if the need arise. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp Associate Director to secure and administer treatment, including hospitalization, for staff member named above. This completed form will be photocopied and taken in a locked bag for trips taken outside of camp grounds.

Applicant's Signature ______________________________Date_________________________

Printed Name: ___________________________________ Date_________________________

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