2008 STAFF HEALTH AND MEDICAL RECORDS

Name _____
(Please Print)

HEALTH HISTORY
(Please write "past" or "now" or leave blank to indicate health history.)

Asthma _____ Epilepsy _____ Hay Fever _____
Kidney disease _____ Rheumatic Fever _____ Sinus trouble _____
Heart trouble _____ Glasses _____ Ear tubes _____
Severe Stomachaches ___ Contact lenses _____ Fainting spells _____
Diabetes _____ Tuberculosis _____ *For Girls:*
Menstrual problems _____

ALERGIES OR ALLERGIC REACTIONS
(Check if YES and please describe what happened.)

_____ Penicillin_____
_____ Other medications (list) _____
_____ Bee sting _____
_____ Food _____
_____ Poison oak, poison ivy _____
_____ Other (list) _____

SERIOUS ILLNESSES OR OPERATIONS
(Please list and explain any serious illnesses or operations during the last five years.)

Illness or Operation _____ Date _____ Hospitalized? YES NO

MEDICATIONS CURRENTLY BEING TAKEN
(Please list each one, give reason for taking and number of times per day needed.)

Medication _____ Times/Day _____ Reason _____
Medication _____ Times/Day _____ Reason _____
Medication _____ Times/Day _____ Reason _____
Medication _____ Times/Day _____ Reason _____
Medication _____ Times/Day _____ Reason _____
Medication _____ Times/Day _____ Reason _____
Medication _____ Times/Day _____ Reason _____

IMMUNIZATION HISTORY
(Please list the dates of basic immunizations and most recent booster doses.)

Last DPT _____ Last Polio _____ Chicken Pox _____
MMR _____ Hepatitis B _____ Tetanus Booster _____

SPECIAL DIET REQUIREMENTS

Regular _____
Diabetic _____
Other _____ Please Explain _____

PHYSICAL ACTIVITY
(Please have your medical professional address any activity restrictions for medical reasons on the Health Exam Verification form.)

Other Health Concerns _____

PERSON TO INFORM IN CASE OF ACCIDENT OR EMERGENCY

Name _____ Cell Phone _____ Work Phone _____
(Parent/Guardian)
Address _____ Home Phone _____

(If not available in emergency, please notify:)
Name _____ Cell Phone _____ Work Phone _____
(Someone not living with you)
Address _____ Home Phone _____

PHYSICIAN TO CONSULT IN CASE OF ACCIDENT OR EMERGENCY

Name _____ Phone Number _____

Address _____

INSURANCE INFORMATION AND CONSENT TO MEDICAL TREATMENT RELEASE

Name of Insured _____ Member # _____
Ins Co Name _____ Group # _____ Phone # _____

This health history is correct so far as I know and the person herein described has permission to engage in all camp activities, except as noted by the physician and me. I, the undersigned parent or guardian of the applicant, a minor, do hereby consent to any radiological procedure (x-ray), examination, anesthetic, medical/surgical diagnosis/treatment, and hospital service that may be rendered to said minor under the general/special instruction of above named physician/any physician the camp may call, whether such diagnosis/treatment is rendered at the office of said physician, at a licensed hospital, or at the camp. It is understood that in the case of a major accident/illness, reasonable effort will be made to reach the parents. It is further understood that this consent is given in advance of a specific diagnosis/treatment, which might be required and is given to authorize Sunset Lake Camp or the physician to exercise his/her best judgment as to the requirement of such diagnosis/treatment. This consent shall remain in continuous effect until revoked in writing or until said minor is removed by the parent or guardian from the care of Sunset Lake Camp. I hereby authorize any hospital/physician/any other person who has attended/examined said minor to furnish the camp's insurance company or its representative any and all information, treatment, and copies of all hospital/medical records. A photo static copy of this authorization shall be considered as effective and valid as the original.

Signature _____ Date _____
(Parent/Guardian (if under 18) or Staff)