

# Summer @Carroll

## 2010 Staff Medical Information and Health History

PLEASE BE ASSURED THAT ALL INFORMATION DISCLOSED WILL BE TREATED WITH TACT AND CONFIDENTIALITY.

**Please complete this form and sign at the bottom. In addition, please attach a CERTIFICATE OF IMMUNIZATION PROVIDED BY A DOCTOR.**

Name: \_\_\_\_\_

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

Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

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

### **Emergency Information**

*In case of emergency, please contact:*

**Contact Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

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

Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

### **Insurance Information**

Carrier or Plan Name: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Group #: \_\_\_\_\_

Name of Physician: \_\_\_\_\_

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

### **HEALTH AND MEDICATION**

1. Allergies: (check those that apply)  bees  insect bites  pollen  foods  medication  Epipen  
If so, what and what type of reaction? \_\_\_\_\_  
\_\_\_\_\_

2. Please describe any medical conditions or restrictions to activity (what cannot be done, what adaptations or limitations are necessary): \_\_\_\_\_  
\_\_\_\_\_

3. Have you been exposed to any communicable diseases within the past 21 days?  Yes  No  
If yes, What? \_\_\_\_\_

4. Medications taken at home \_\_\_\_\_

5. Medications taken at camp? Are you bringing medication or pills of any sort to camp?  Yes  No  
If so what: \_\_\_\_\_

6. Other Information: \_\_\_\_\_  
\_\_\_\_\_

Staff Member's Signature \_\_\_\_\_ Date \_\_\_\_\_