

WILLOW LAKE DAY CAMP STAFF HEALTH HISTORY AND MEDICAL FORM

WILLOW LAKE DAY CAMP
P.O. BOX 1266 HIGHLAND PARK, NJ 08904
973-663-2732

PLEASE RETURN THIS FORM BY MAY 15

Name _____ **Age** _____ **DOB** _____

Home Address: _____

Home Telephone: _____ Cell Phone: _____

E-Mail Address: _____

Emergency Contact Person _____

Relation _____ Telephone _____

Name of Physician _____ Telephone _____

Health Insurance Provider _____ Policy # _____

Name of Insured _____ Group # _____

HEALTH HISTORY

Does the employee have any allergies (food, drugs, plants, insect, etc.)?

Please List:

Does the employee have any recurring illnesses or conditions?

(Circle: Yes or No) If yes, explain:

Does the employee have any restrictions to camp activities?

(Circle: Yes or No) If Yes, explain:

Has the employee had any serious injuries, past medical treatment, or operations? (include approximate date)

Describe any current physical, mental, or psychological conditions requiring medication, treatment or special considerations while at camp:

List all current medications taken, prescribed and over-the-counter:

Are there any additional health concerns which the camp should be aware of?

DISEASES

DATE OF LAST IMMUNIZATION

Tdap	_____
Measles, Mumps & Rubella	_____
Varicella	_____
Hepatitis A	_____
Hepatitis B	_____
Pneumococcal	_____
Meningococcal	_____
Date of <u>last</u> Tetanus shot:	_____

If you have any questions in regards to your immunizations, please contact your physician.

PERMISSION TO PROVIDE NECESSARY TREATMENT OR EMERGENCY CARE AND ADMINISTER MEDICATION

I hereby attest to the above information being true and give permission to the medical personnel selected by the camp director to order x-rays, routine tests and treatment for me in the event that I am unable to speak in an emergency. I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and /or anesthesia and/or surgery for me as named above. This form may be photocopied for use out of camp.

Signature of Employee: _____ Date _____

Signature of Parent or Guardian _____ Date _____
(if employee is under 18 years of age)