STAFF HEALTH HISTORY

_____ adult _____minor_____

last name first name initial

_____ _____

street address home phone

_____ _____ _____

city state zip date of birth sex

_____ _____

name of parent/guardian/spouse phone number

_____ _____

address of parent/guardian/spouse if different from yours work/emergency phone

CAMP YOU WILL BE COUNSELING FOR:_____

.....

Health Insurance Company _____ Contract # _____

Plan Code _____ Group # _____ Coverage Code _____

Family Physician _____ Phone _____

IN AN EMERGENCY, I grant permission to Bay Shore Camp to secure emergency medical aid and surgical treatment, and routine non-surgical medical care for the staff member named on this form while at camp. I also certify that the information on this form is correct to the best of my knowledge.

_____ _____

signature of staff member if adult OR parent if minor date

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List all allergies:

List any health problems:

List any physical limitations:

Do you currently have or have you been recently exposed to any infectious diseases? Yes ◯ No ◯

If yes, please explain.

Medications taken regularly (including psychiatric):

Name	Frequency	Dosage