EAST OHIO CAMPS
EMERGENCY MEDICAL FORM

TO BE COMPLETED ANNUALLY BY ALL STAFF

STAFF INFORMATION: (Please Print)

NAME:		DOB: / /	AGE:
ADDRESS:		HOME #: ( ) -	
CITY:	STATE: ZIP:	CELL #: ( ) -	
POSITION:	SITE:	SSN:	

EMERGENCY CONTACT INFORMATION: (Please Print)

FIRST CONTACT		
NAME:		DAY PHONE # ( ) -
LAST	*FIRST*	EVENING PHONE #( ) -
RELATIONSHIP TO STAFF:		MOBILE PHONE #( ) -
SECOND CONTACT		
NAME:		DAY PHONE # ( ) -
LAST	*FIRST*	EVENING PHONE #( ) -
RELATIONSHIP TO STAFF:		MOBILE PHONE #( ) -
THIRD CONTACT		
NAME:		DAY PHONE # ( ) -
LAST	*FIRST*	EVENING PHONE #( ) -
RELATIONSHIP TO STAFF:		MOBILE PHONE #( ) -

INSURANCE INFORMATION: (Please Print)

PLEASE FILL OUT INFORMATION BELOW OR ATTACH A COPY OF THE FRONT AND BACK OF THE INSURANCE CARD. ALSO, IF YOU HAVE A PRESCRIPTION CARD, PLEASE ATTACH A COPY OF FRONT AND BACK.

INSURANCE HOLDER'S PERSONAL INFORMATION		**INSURANCE COMPANY INFORMATION**	
NAME		COMPANY	
SSN	DOB __/__/____	ADDRESS	
ADDRESS (IF DIFFERENT THAN CAMPERS)		CITY	STATE
ADDRESS		ZIP	
CITY	STATE	INS. CO. PHONE #	
ZIP		GROUP #	
EMPLOYER		ID #	

Staff Member Authorizations:

I agree to the release of any records necessary for treatment, referral, billing or insurance purposes for the staff person named on this health form. IN CASE OF MEDICAL ILLNESS OR INJURY, I hereby give permission to the camp to obtain proper medical care for the staff person named on this health form if he/she is not able to authorize on their own. IN CASE OF MEDICAL EMERGENCY or in the event that the named staff person is not able to authorize on their own, I understand that every effort to reach the emergency contacts listed will be made. If no one can be reached, I hereby give permission to the attending physician to hospitalize, secure proper treatment for, order injection, anesthesia or surgery as necessary for the staff person named on this health form.

Signature:____**Date:**______________________

(if staff person is under the age of 18, parent/guardian must sign and date)

HEALTH FORM

Name:		Position:	Site:
Age:	Height:	Weight:	❑ Male ❑ Female

Do you have any of the following conditions:

❑ ADD ❑ADHD ❑ODD ❑Behavior Problems
❑ Anemia currently
❑ Asthma ❑ other Lung Disease
❑ Bed Wetting ❑ Frequent Urinary Infections
❑ Diabetes
❑ Ear Infections ❑ Tubes in Ears Currently
❑ Eating Disorders ❑ Anorexia/Bulimia ❑ Obesity
❑ Epilepsy ❑ Absence Spells ❑ Grand Mal Seizures
❑ Hay Fever/Seasonal Allergies
❑ Hypertension ❑ Heart Disease
❑ Mental Health Concerns ❑ Anxiety Disorder
❑ Depression ❑ Bipolar Disorder
❑ Menstrual Concerns LMP prior to camp __/__/__
❑ Sleep Walking ❑ Sleep Talking
❑ Sprains, Strains, Muscle, Bone or Joint Problems
❑ Stomach problems ❑ Diarrhea ❑Constipation
❑ Other diagnosis or concerns:___________________

____

Explain conditions checked above including required medications, treatments, special restrictions or considerations while at camp: ____________________

____
____
____

Surgeries/Serious Injuries/Broken Bones
Please List with Date: ❑ None

____
____

Allergies:
❑ None Known
❑ Insect/Bee Stings
❑ Serious/Life threatening reaction
❑ Localized swelling or redness at site
❑ Medication Allergies
❑ Serious/Life threatening reaction
❑ Hives, rash, diarrhea, other
Please list Med Allergies:_____________
____
____
❑ Food Allergies
❑ Serious/Life threatening reaction
❑ Cramps, diarrhea, hives
Please list Food Allergies:_____________
____
____
❑ Other Allergies: _______________
____
____
❑ Carries Epi Pen
❑ Carries Emergency Inhaler

IMMUNIZATION HISTORY:

Date (month/year) of your most recent tetanus immunization: ___________________________________

Have you completed the immunizations that were required for school attendance? ❑ Yes ❑ No

CURRENT MEDICATIONS AND INHALERS: (both ***prescribed*** and ***over-the-counter*** - add additional page if needed)

Drug Name	Dosage	Time of day to be administered	Reason for Medication

I require medication that may impair my ability to perform the essential functions of my position. ❑ Yes ❑ No
If yes, I will discuss the details with the camp director and/or healthcare provider. Initial: ___________

Name of Staff Members Physician:______________________________Telephone:______________________

RESTRICTIONS: (Check one)

❑ I have reviewed the job description's essential functions and feel that I can perform the essential functions of my job without restrictions.
❑ I have reviewed the job description's essential functions and feel that I can perform the essential functions of my job with the following restrictions or adaptations: ____
____

Staff Members Signature: _______________________________________Date:_______________________