Camp Fatima
Exceptional Citizens Week

Staff Health Record

Name:

SSN#:

Address:

DOB:

Age:

Parents Name:

Home Telephone Number:

Where can you parents or guardian be reached at while you are at camp?

Name
Street Address

City
State
Zip Code
Telephone Number

Are you subject to: (Check if Yes)

Headaches	Convulsions	Colds
Tonsillitis	Constipation	Food Rashes
Earaches	Stomach Aches	Sinus Trouble
Sleep Walking	Athletes Foot	Hay Fever

Have You Had:

Measles	German Measles	Hernia
Mumps	Rheumatic Fever	Heart Trouble
Asthma	Scarlet Fever	
Typhoid	Infantile Paralysis	
Diphtheria	Chicken Pox	
Whooping Cough	Pneumonia	

Have you been exposed to any contagious disease within the last three weeks?
If so, What?:

Have you been vaccinated for or inoculated for:

Tetanus	When:
Salk Vaccine	When:
Measles	When:

Have you had or been classified as a carrier of Hepatitis A?
And have you been immunized?

IMPORTANT: Our camp health/accident insurance will not cover staff for Exceptional Citizens' Week. All staff requiring medical attention must be covered under their own or their parents insurance. Please bring necessary information with you to camp.

-NEXT PAGE-

Are you taking and medication of any kind?
If so, what (please explain dosage, times, ect)?

IMPORTANT: Any and all medication must be left with the nursing staff in the infirmary. This includes everything, even aspirin. No medications can be in your living quarters.

Do you have any physical disabilities that our nurse should be aware of?

Have you ever had a serum reaction?
If so, please explain.

Are you sensitive or allergic to any food or medication?
Please list all:

Can you take penicillin orally or by injection?

Date:_____________ **Signature**:___________________________

Guardian or parent signature:
(If you are under the age of 21, a signature of a parent or guardian is required)

Please note: No doctor's physical exam is required. However, this form should be completed prior to your arrival at camp. It is important that you cooperate in make sure that our Infirmary has a medical form on you. We thank you for your help.

Your doctor's name:
Address:
Telephone:

The following permission is very important. Should you require hospitalization or other medical services while at camp, this consent is necessary in order to obtain treatment.

Consent to operate, anesthetic and other hospital medical treatments and services.

In the event I cannot be reached in and emergency, I hereby give my permission to the physician selected by the Camp Director to hospitalize secure proper treatment for, and to order injections, anesthesia or surgery for my child as named on this health record.

Date:_____________ **Signature (parent/guardian):**____________________

Not required if you are 21 years of age