Emerald Cove
OUTDOOR SCIENCE INSTITUTE

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# Staff Health History Form

Name _____ Male Female
First Middle Initial Last

Mailing Address _____
Street Address City State Zip

Date of Birth ____/____/_____ Age_____ Birth State _____ SSN _____-_____-_____

Drivers License # _____ State _____ Phone # _____

## Health Report

Health Problems / Any Restrictions: _____

_____

Drug Allergies / Allergic Reactions (If allergic to bee stings, you must bring Epi Pen to camp): _____

_____

Dietary Restrictions: _____

_____

Medications (Must be brought in the prescription bottle with label): _____

_____

Past Medical Treatment (surgery, disease): _____

_____

## Immunization Report

- Approximate Date of last tetanus shot/booster _____ (Current tetanus is required).
- Chicken Pox Vaccination: Yes / No Approximate date of Chicken Pox:_____
- Hep B Vaccination: Yes / No
- MMR Vaccination: Yes / No
- TB Screen: Yes / No Result: _____ Date: _____
  (Documentation of Neg. Results Required for Employment)

## Personal Information

Spouse/Parent/Guardian Name (If Applicable) _____
Primary Phone _____ Alt. Phone _____
Emergency Contact's Name _____ Relationship _____
Primary Phone _____ Alt. Phone _____
Medical Insurance Company _____ Policy # _____
Insurance Co. Address _____ Phone # _____

Signature: _____ Date: _____

**All staff members must have had a medical examination by a licensed physician within the past 24 months.**

1) Please attach a copy of your health examination record.

- or -

2) Have a licensed physician complete the verification of health examination form below:

## Verification of Health Examination

_____ had a health
( name of staff member )

examination within the past 24 months, specifically on _____.
(date of exam)

1) Please describe any current or ongoing treatment or medications : _____

_____

_____

2) Please describe any physical condition that might require restrictions on participation in camp activities or program : _____

_____

_____

_____ _____
(Signature of physician) (Date)

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